MENTAL HYGIENE

VOL. XXIII JANUARY, 1939 No. 1

THE SIGNIFICANCE OF RESEARCH IN MENTAL DISORDERS *

ALAN GREGG, M.D.

Director for the Medical Sciences, The Rockefeller Foundation, New York City

IN venturing to consider with you the meaning and value of your support of research in mental disorders, I recall a curious and stimulating remark of a teacher I had in college. We were talking about religion. "What would be heaven?" was the question. By good fortune the philosopher Royce was there. When asked what his idea of heaven was, he replied, "It would be heaven to know at every instant the full significance of what I am doing." An unusual reply. A baffling idea. A thought quite unexpected by a boy of eighteen, indeed scarcely comprehensible at once, but so simple and so strange that it received and has long deserved repeated reflection ever since. To know the full significance of what you are doing: this would mean to know its origins, its values, its connotations, its relationships, its by-products, and its end effects. A large order; indeed with something noble in its sweep. With what speed would we desist from some things, and with what peace and confidence we would persist at others! It is to the significance of what you are doing in the support of research in mental diseases that your guest ventures to draw your attention to-day, half inclined to think that it would be heaven to know, but at least in the lively hope that a fuller realization of the meaning of what you are doing may bring to you something beyond ordinary horizons or the workaday ceiling of routine.

* Delivered before the Supreme Council, 33°, Northern Masonic Jurisdiction, U. S. A., Columbus, Ohio, September 27, 1938.

A notable fraternal order is devoting funds to the support of psychiatric research. What is the significance of that? Where shall we place such a fact in relation to thousands of events in the history of medicine already recorded or in times still to be recorded?

Let us first attempt to escape from trivial comparison and take the long view of history. Now what has happened in Medicine has depended to a peculiar degree upon prevailing attitudes or beliefs that men have held in different ages regarding disease and suffering. Disease and suffering have not always been interpreted as we interpret them. Let us consider four successive epochs in recorded history, each with its characteristic philosophy regarding suffering: Old Testament times, the era of Greek civilization and thought, the time of the growth and spread of Christianity, and the more recent period, say from 1800 to 1860. Each of these eras had its peculiar attitude or view of disease. And each of these accepted views in turn influenced and indeed almost determined the efforts mankind could make regarding disease. These beliefs have varied through the ages and the well-informed student of medical history can readily point out the natural consequences of changing attitudes to pain and disease.

The ancient Jews believed that pain and disease were punishment for sins—"even unto the third and fourth generation." They believed that Jehovah punished his wayward people with pestilence and pain for transgressions or lapses of a moral character. Suffering was made rational by drawing upon guilty feelings. Such interpretations have not ceased even yet. One of my first patients was a New Englander who reproached himself for rheumatism in an agonized admission that it was all due to his enjoyment of apple pie. Now if punishment was the meaning and purpose of suffering, who would be so rash as to consort with sinners or dare to interpose a merciful hand to dispute or deflect the wrath of Jehovah by caring for the sick? When men regarded pain and suffering as Divine punishment, the reasoning mind discreetly refrained from the insolence of interference. The leper was shunned, not ministered to nor studied. And so,

quite naturally, we owe but little medical knowledge to the early Jews. Their accepted views precluded their obtaining the knowledge that is power.

A change came with the Greeks, whose views of suffering and disease were of a new sort. The best Greek thought held a healthy man to be in beautiful balance or harmony, a sick man like a lyre with a loose string, needing correction to become in tune with himself and his environment. Disease was a blemish, something to be corrected, a failing, not a failure, and not personal castigation by a relentless and vindictive God. There was little or no guilt about it, and the sick man was at liberty to seek restoration, and his friends did not fear to aid him. That attitude permitted the clear-sighted observation and the calm reasoning that began the study of medicine and is so remarkable in the heritage we have from Hippocrates. As soon as disease could be regarded as something apart from God's ineluctable will, the care and prevention of disease fell open to observation, reflection, and record, and thus teaching and the accumulation of experience. But there was little in the Greek view to combat the natural aversion to the leper, and nothing to encourage associating with him; it was the sick man's problem to seek harmony for himself.

With the advent of Christianity, still another attitude toward suffering gained credence and practical acceptance. "Whom the Lord loveth He chasteneth." The belief became prevalent that through suffering men could attain eternal glory. Sufferers were therefore regarded as a kind of moral élite, singled out for the honor of extreme trial, fortunate, blessed by their tribulations. To associate with them became something between a duty and a privilege, and thus was born an institution of incalculable value to medicine, the hospital. Hôtel Dieu—the guest house of God—still the name of one of the great hospitals of Paris. And so from the Christian attitude of pity and charity to the sick came that institution which was to be the source and fountainhead of so much progress in Medicine, the hospital. For it meant and still means the possibility of becoming familiar with disease. These collections of the sick made with the support

and favor of the Church were of importance, for of collections is born comparison, and comparison is the beginning of study —of differentiation and thus diagnosis. Ministering to the sick was considered pious—not an affront to God nor the kindliness to be expected only from an intimate. Had not Christ Himself healed the sick by His miracles?

It is surprising that there was not more reluctance to interfere with pain if pain was a favor conferred by God. But that there was some such reluctance can be easily verified from the relatively recent history of the adoption of anæsthetics. It was only against stern clerical protests that ether came, less than a hundred years ago, to the easement of childbirth.

But the important aspect of the Christian interpretation of suffering was that it explained disease to the moral advantage of the sufferer and to the credit of his attendant. The sick man was not avoided nor despised. He was helped and made free to choose between glorious pain and the chance of relief promised him by the followers of Hippocrates.

And now almost within the memory of man comes still a different epoch in medicine. Call it scientific if you choose. It is essentially naturalistic and rational. To Christian pity for the sufferer, it adds enlightened self-interest in avoiding the spread of communicable disease. It is in a sense unemotional, calm, without guilt or superstition or supernatural implications. Health is coming to be regarded as the natural state—almost as a civic right, like life, liberty, and the pursuit of happiness, and health is already, in certain ranges at least, a purchasable commodity. Disease no longer has an intense religious or moral meaning, but is regarded as a condition yielding to inquiry, following natural laws, often social in its implications and probably susceptible of control—a natural phenomenon. Our generation can scarcely realize how great a relief from fatalism, superstition, guilt, and terror this change is bestowing upon us. Our fathers could not fail to see the change; our children will be unable to imagine it unless they travel and live intimately in primitive cultures still struggling without the benefits of this new attitude.

I have laid heavy emphasis upon these four successive eras of interpretation of the meaning of disease because you must realize that the layman's view and the prevalent attitude toward disease is of immense importance in determining what can be done about it. And this is terribly true for progress in understanding mental disease, which depends so critically upon what accepted interpretation is placed upon it.

We are, then, in the first hundred years of a new attitude toward disease. Its first strength became evident through the discoveries of Pasteur, Lister, Virchow, and a host of others. These discoveries laid open to rational interpretation and practical control a wonderful series of diseases due to bacterial or parasitic invasion. The curtain is not yet rung down upon the spectacle of man conquering through research the greatest plagues of humanity, for we have the field of virus diseases—such as yellow fever, poliomyelitis, influenza, and probably the common cold—still yielding to study or to progressively better methods of control. But probably the greatest discoveries of bacteriology are already recorded, and what remains in the conquest of bacterial diseases is the immense, but essentially hopeful and clear-cut task of refining and applying our knowledge.

That sounds hopeful. But not all diseases are due to parasites, bacteria, or viruses. There are diseases and defects due to malnutrition; there are hereditary defects and diseases; there are diseases characteristic of advanced years; and there are still diseases whose full nature is unknown, conspicuous among them cancer and some mental diseases and disabilities. Need it be said that here are the fields for immediate and future study? But of all these unsolved problems this at least can be said with historical perspective: we have now attained an attitude that permits us to study them, to observe, to reason, to conceive of causes, and to test our concepts by trial and experiment.

I said "permits us to study," for in the case of psychiatry it could not be said that we have attained an attitude which encourages us to study them—not as long as the funds for research in psychiatry bear the present miserable ratio to the cost of routine care of the insane. You will understand the significance of your contribution the better if you under-

stand the handicaps under which research in psychiatry seeks to proceed.

"Nothing succeeds like success"—and it is a primary handicap of psychiatric research to-day that mental diseases did not yield to the concepts and methods of the past fifty years of bacteriological and pathological research as did the infectious diseases and surgical sepsis. Not having enjoyed so miraculous an advance, psychiatry has not invited so large a number of investigators. Many in the medical profession have looked down upon the whole field of mental and nervous diseases. They have said, "What can you do?" "Where are the leads?" "We don't talk the same language as those psychiatrists." And so to the geographical isolation of the asylum and the heavy responsibilities of custodial care was added a certain intellectual isolation whose marks are still observable. Again the subtle effects of attitudes.

But as a sort of natural readjustment, the importance of a better knowledge of the mental and emotional life of man is asserting itself. The triumphs of the past fifty years automatically reveal our present remaining incapacities in sharper contrast, and more time and effort are being spent on psychiatry in the medical schools than could have been expected fifteen years ago. Research upon the structure and function of the nervous system, and upon the behavior of the organism as a whole, is increasing in quantity, in quality, and in attractiveness to superior research talent.

Another obstacle for research in mental disease deserves your attention and your understanding. Most diseases begin or show their presence first by changes like pain, weakness, fever—pitiful and noticeable, but not morally alarming or socially dangerous. But suppose a disease begins with a loss of good judgment or self-control as the very first sign. What a confusion for all concerned! The disapproval and resentment we visit upon foolishness or immorality is immediately attached to such a disease. We may as well admit that it takes great self-control for *healthy* persons to follow the rules of civilized behavior, to say nothing of the difficulties of fulfilling the demands of Christian ethics. If it happened that one of the first symptoms of a disease was not a chill or a headache, but a loss of self-control, how could we who are still strug-

gling for self-mastery easily condone the sufferer's lapse? We should think he wasn't suffering—we should suspect he was enjoying it. Not until his misbehavior became unendurably flagrant would we concede that he was ill and then, with almost uncontrollable aversion, we should put a taboo upon him and his disease. Again disease would be tainted with a moral flavor as it was in ancient India or as it is among primitive peoples to-day. And thus we would forego the moral credit of associating with such a sick man. And so lose the opportunity to be familiar with his disease. Now that is what happens in many mental diseases. From such circumstances comes a moral aversion amounting to horror of diseases that actually do show themselves in ways that break down social relationships, offend our moral sensibilities, our fastidious tastes, and our emotional equanimity. And so there is an immense taboo on mental disease—a taboo resembling the savage's terror and quite as inimical to observation, reasoning, and study. Happily and hopefully it is lifting, but let us understand that it exists and why it exists, for here especially we should recall the ancient "Ye shall know the truth and the truth shall make you free."

Perhaps one other aspect of your aid deserves explanatory comment. Your funds are for research on dementia praecox. That is a classification or name. You will hear it called schizophrenia. You have heard hard times called depression or even recession. It is the same—at least the same name for probably a lot of different, though similar, diseases. Until we know a great deal about something, different people will call it by different names. And all Chinese look alike until you have lived in China. And from 1609 till 1889 our forebears fought Indians. The fact that they weren't Indians or inhabitants of India did not stop the fighting. Indeed medical history is full of instances of a number of different and ultimately distinguishable diseases being grouped under a single (albeit learned) name until further study gave the basis for differentiation. The names may change or be discarded or subdivided, but that will mean progress and not bewilderment or failure.

Let us take stock of the situation your support is already ameliorating. You must realize the deadening effect of the

common view of insanity—namely, that body and mind are totally separable; that the care of mental disease is wisely separable from general hospitals and the rest of medicine; that mental disease is probably hereditary, usually hopeless, and certainly disgraceful; that a low per capita cost is the best evidence of proper administration; and that the most sensible procedure is to put no good money into studying crazy people. As a result of these and similar attitudes, the proportion of fine minds working on the problems in state mental hospitals is discouragingly small, the budgets for research admittedly lamentable, public ignorance almost paralyzing, and careers for scientific investigators few and scantily supported. I hate suffering, bewilderment, confusion, despair, loss of freedom, neglect, and indifference, but it would be hard to deny that these insults to the spirit of man thrive as long as we accept the common view of insanity.

In such circumstances, *you* are pioneers. What in the main are you accomplishing? I suspect you do not realize in how many directions your funds have admirable results. First, there is the chance—naturally a very small chance, but who knows?—that by virtue of your aid some single discovery will lead straight to the cause and cure of one of the kinds of insanity. It would be more probable that your support will forge several links in a chain of observations and reasoning that will control schizophrenia or some of the derangements now called by that name. Or, as often happens, work done upon your grants may uncover unexpectedly some information of great value to another sector of medicine. Please remember that Columbus started out to discover a way to India.

But great risks for high stakes is not the whole story. You cannot count failure to make some such discoveries as a failure of your policy, for you are doing much more already than search for the cause and cure of schizophrenia. You are building an attitude toward disease—toward mental disease where the previous attitude was and is so futile and evasive.

The mere existence of research work in a mental hospital improves the care given all the patients. They are seen more often, some are watched far more attentively. It is like intro-

ducing accounting in a business house. Records are kept. Failures are recognized and reproved. This you are accomplishing wherever your fire has lit the investigator's lamp.

Can you not imagine what it means to some of the patients to have special interest shown them—some effort to study and perhaps prevent the thing they fear so abjectly? Evidence is accumulating that mental patients apprehend more than has seemed probable of what is the attitude of those around them.

Certainly you are giving encouragement to those medical scientists and physicians who have wanted to do research work. And you have encouraged some younger men to prepare themselves for careers in psychiatric research.

Some of your own members have become aware, through your own discussions, of the extent and importance of mental disease. They have already, as public leaders or private citizens, taken measures that enormously enhance in certain states the prospects of adequate care and study of the insane.

Furthermore, you have heartened those of us in foundations in our efforts in the same direction. We know that foundations alone cannot expect their efforts to be adequate. And your faith and eagerness have called from The National Committee for Mental Hygiene a rare measure of time and thought on the part of the special Advisory Committee and the services of Dr. Nolan Lewis.

Perhaps it may be asked by some of you, "But what is the use of our giving $50,000 a year to such a purpose when some agencies are contributing more?" It is such support as yours that makes probable the larger support. I know of no foundation whose trustees would continue to vote funds if they thus eliminated the interest and collaboration of others. Indeed, most foundation grants are made on the condition that funds be obtained from other sources on a one-to-five or a fifty-fifty or an eighty-five-to-fifteen ratio. Many is the time I have seen a private donor unlock with a relatively small sum a large foundation grant which was conditional upon his measure of collaboration.

Need I explain the use, the permanence, the almost incalculable economy and grace of sound knowledge once it is acquired? For all its beauty, nursing care is not a better

investment than effective treatment, nor is sympathy preferable to prevention. "God sells knowledge for sweat," said the old Bishop of Norwich. And he might have added that ignorance costs blood or tears. Think of what accurate knowledge secured by research into the causes of malaria, tuberculosis, typhoid, diphtheria, diabetes, and pernicious anæmia has meant. The sympathy, the care, and the cost all saved by knowledge. Is it not time to seek for more knowledge of mental diseases?

Have I made you understand more completely the significance of what you are doing? Do you see the possibilities more clearly and the certainties more happily? I could hope that you who have so much encouraged me will catch and hold the encouragement I seek to give you back.

But to the encouragement I would add a suggestion or two. If research in mental disease is to attract fine research minds, and if it is to be successful, time is needed, not merely increased funds. Fifty thousand dollars a year for ten years in superior hands is usually better than a million over a two-year period in the same hands. Tenacity of purpose and seriousness of intent are worth more than princely, but wavering generosity. Why? Because the test of time must be met by any theory of cause or method of cure. Brilliant ideas need stages of trial and development as well as mere initiation. You must be patient and perhaps long-suffering in this task; the sick you seek to aid have long been that. Can you match the afflicted in their willingness to wait and to hope? And may I suggest that some of you have the courage to inquire in your own states what is the budget for steady and continuing search upon the causes of the mental disorders for which such huge sums are being spent? Or to visit the institutions and see what a sad state of human suffering your funds are spent to render needless?

You are in the front line of your generation. Your money is liberating the energies of men who want to study mental disease to put an end to it; your confidence challenges their best efforts. You are encouraging the desperate and the forsaken and their families, dumb in their mistaken disgrace. You are an example and a stimulus to others who are attempting to aid in the mastery of mental disease. But best

of all, as a notable fraternal order, you are builders of a new attitude toward mental disease, facing disease and terror with the hope of attaining calm and effective knowledge.

Research has been called a guerilla warfare on the unknown. Perhaps you may remember the taunt Henry the IV called to the tardy Crillon, "Hang yourself, brave Crillon; we fought at Arques and you were not there." Well, I congratulate you on your remoteness from such a charge, and I hope, in eager admiration of what you are doing, that I have helped you see where you are in the guerilla warfare on the unknown.

THE PERSONALITY PROBLEMS OF TEACHERS*

HARRY N. RIVLIN, PH.D.
College of the City of New York

EVEN a casual comparison of modern education with that of twenty-five years ago is enough to show how much progress has been made in such important phases of education as the curriculum, methods of teaching, and procedures in testing. Moreover, our journals are full of reports of experiments and investigations which promise even greater strides forward. In the face of all these studies and all this progress, it is surprising how often investigators have virtually overlooked the obvious fact that the personality and the professional equipment of the teacher are basic factors in determining the success with which education achieves its goals. There is a general tendency to speak of education in terms that are too abstract—to think, for example, of the aims of secondary education without realizing that what secondary education will accomplish depends on what this teacher does with his class and upon how that principal runs his school. Thus, one asks of what value is it to formulate anew the reasons for teaching the novel in high schools unless these principles are put into practice when Mr. Brown's class studies *The Return of the Native* and when Miss Smith's pupils read *The Bridge of San Luis Rey.* It is disappointing to see that investigators have almost ignored the possibilities of changing the teacher's personality. At no time has the teacher himself been the subject of such intensive study as has been directed to the other phases of the educative process.

When we come to the study of the teacher's personality, we are faced with the difficulty that we really don't know what the teacher's personality is like at present or what it

* Presented on the Schoolmen's Week Program of the University of Pennsylvania, Philadelphia, April 1, 1938. It appeared on the program under the title, *Can Teacher Personality Be Improved?*

should be like in the ideal situation. There is always the danger of accepting the cartoonist's caricature of a teacher as a realistic description of a typical teacher. Similarly, in the studies that have been made of the teacher's personality by psychologists and psychiatrists, it is often the extremely maladjusted teacher who is investigated and not the kind of teacher who is to be found in most of the classrooms of the country.

Educational research has employed many kinds of approach in its attempt to discover the personality traits necessary for successful teaching. Some investigators have asked supervisors to note the characteristics of successful and of unsuccessful teachers. Others have asked pupils to describe the qualities of teachers whom they liked and of those whom they disliked. In one study, college students were asked to describe the teachers they had had in their elementary- and secondary-school days, and the investigators then noted the qualities of those teachers who had made a lasting impression, whether favorable or unfavorable, on their students. Using still another approach, some investigators prepared rating scales and questionnaires as bases for evaluating teachers on traits considered to be significant.

Certain conclusions follow inevitably from the various investigations. First, personality traits are important factors in determining a teacher's success. Thus, in almost every evaluation of a teacher's equipment, personality traits hold a prominent place. Secondly, many different types of trait are mentioned and there is no unanimous agreement as to which single trait is most important for a teacher's success. Thirdly, the traits that are desired in teachers are not markedly different from those desired in other professions. They suggest that the teacher must be an alert, interesting, well-adjusted person. Obviously such an individual can succeed in almost any profession, but in teaching, his personality traits are especially significant. One may as well admit that any person of average intelligence and with a fair knowledge of the subject matter can become a mediocre teacher. But if he is to be successful in the classroom and if he is to find lasting satisfaction in his work, his superiority in personality traits must be marked.

Despite the variation that is found among the reports of different investigators, there is agreement on the need for certain basic traits of personality. The differences in the findings of the investigators are often more a matter of words than of actual contradictions in the enumeration of the traits. What are the characteristics that we find in a successful teacher? First, there is professional zeal, with interest in the process of education and the ability to continue his mental and professional growth while he is on the job. Second, there is a conviction that education is significant and that in the process of education his is an important rôle. Third, there is a sense of self-assurance and self-confidence which leads him to recognize the problems growing out of his work and to feel that he will ultimately be able to solve them. Fourth, he responds to intelligent criticism without being offended or feeling unduly sensitive. Finally, he treats his students calmly and impartially without projecting upon them his own biases and prejudices or using them as a means of solving his own emotional problems. These five traits—professional zeal, faith in education, self-confidence, responsiveness to criticism, and impartiality in his attitudes toward students—are not the only ones that have been mentioned, but they are sufficient to indicate the nature of the problems that are faced by those who are trying to change teachers' personalities.

Once we have decided what traits are needed by teachers, the question arises what can be done to modify the teacher's personality traits in these respects. Before any progress toward changing personality traits can be made, one must realize that personality is an integral and not a superficial part of the individual's make-up. The Freudian analogy of the iceberg is useful as one way of looking at personality. Most of the iceberg lies below the surface of the water and is not easily noticed by the untrained observer standing some distance away. However, it is the submerged part of the iceberg that determines which way the ice will drift. Any attempt to control the menace of icebergs merely by trying to move the small part that is visible above the water line will be ineffective. So it is with the modification of personality traits. The only way in which these can be modified is by

getting at their roots in the individual's make-up. It is only by asking why this teacher is oversensitive to criticism, or why that teacher is unfair in her treatment of the various children in her room, that either of these undesirable traits can be modified. When we speak of improving personality, we must remember that we cannot change personality except by modifying the individual himself. An attractive personality is not to be gained by reading a book, by taking a course, or by following prescribed exercises for fifteen minutes a day. Such changes as may come about as a result of these procedures are usually so superficial that their artificiality is readily seen even by the uncritical observer. There is little point in seeing how teachers can be made to feign qualities they do not have. The significant traits of personality are the surface manifestations of an inner emotional balance; they have their origin in the very nature of the person. There is, then, no ready formula by which personalities can be changed, by which old personalities can be discarded and more desirable personalities acquired.

What are the factors that interfere with the development of a wholesome personality in a teacher? This is a problem that must be faced rationally and not emotionally. Personality traits cannot be argued or bludgeoned into being. The problem is fundamentally an educational one and it must be solved as all educational problems are solved—namely, by analyzing the problem, by surveying our resources for dealing with it, by planning a solution, and by evaluating the results.

Let us take a typical illustration of a trait that needs to be modified and see what can be done to effect the change. For example, what can be done for the teacher who is oversensitive to criticism, who is easily offended by any suggestion that is made by his supervisor, even though the criticism is merited and the suggestion is sound? Is it enough merely to tell him that he must learn to accept criticism graciously? Hardly. Before we can offer any specific suggestions to the oversensitive teacher, we must agree on the fundamental procedures to be used in the modification of personality traits. Basically the procedures used in modifying this trait in a teacher's personality are similar to those

used when the teacher modifies an undesirable trait in the pupil's personality.

All teachers realize how futile it is merely to tell the disobedient child that he must be good, to tell the truant that he ought to come to school, or to tell the child who has been stealing that theft is dishonest. The only method by which the teacher can actually cure the child is to find out why he is a truant, or why he steals. It is only by removing the underlying cause that the teacher can hope to change the student's behavior pattern.

Let us imagine that a man who has been feeling ill goes to his physician. The patient complains of pains in his head, insomnia, and sudden loss of appetite. How much respect would we have for a physician who prescribed aspirin as a means of relieving the headache, a sleeping potion to take care of the insomnia, and a concentrated form of Vitamin B_1 for the lack of appetite? The competent physician proceeds in an entirely different way. He tries to find the underlying cause of all the symptoms, knowing that once he has removed the basic cause, the symptoms themselves will disappear.

This plan of procedure applies as well to the correction of weaknesses in the teacher's personality as it does to the correction of the child's behavior difficulties or to the treatment of physical ailments. The surest way of effecting a lasting change is to discover the cause. In as much as it is often difficult to discover the cause, it is no easy matter to change personality.

Another complication arises from the fact that the same cause may lead to different symptoms. For example, three teachers, all of whom feel dissatisfied with their professional attainments, may be entirely different in their individual reactions to the basic difficulty. One of them may become oversensitive to criticism, the second may become over-aggressive in his pursuit of interests outside the school, and the third may become only a routine teacher, satisfied to live along from day to day or even from period to period. Yet the remedial program may be the same in all three cases—namely, to lead the teacher to recognize his abilities as well as his deficiencies and to help him plan a more satisfactory method of overcoming his limitations.

Where shall one look for the underlying causes of the teacher's personality problems? There are at least three major sources that must be considered. Some of the problems arise from the teacher's personal life; some grow out of his relations to his community; and others result from his professional life. Before a teacher can be helped to modify his personality traits, he must study his own personality, his community, and his school.

In our concern with the child's personality, we sometimes forget that teachers, too, have personalities and personality problems. The man who is troubled by financial problems, who is worried about his health, or who is unhappy because of domestic difficulties does not forget his problems merely by setting foot in the classroom. The teacher is first of all a human being and second a teacher. Anything that helps him to live a fuller and a happier life, that brings the rich feeling of inner peace and contentment that comes when his fundamental drives are satisfied, is certain to have a wholesome effect on his classroom personality. Modern psychology and psychiatry have learned so much about the needs of the human being that only a few of the basic principles can be summarized here.

Fundamentally, the ancient prescription, "Know thyself," is still sound. We must recognize our hopes and our fears; we must know our aspirations, our abilities, and our limitations; we must be aware of our likes and our dislikes. Little lasting satisfaction can come from the common practice of dodging our emotional problems and of deluding ourselves into thinking that all is well when it is not. Rationalization, for example, is objectionable, not because it is a way of evading reality, but because it is usually only a poor substitute for an adequate solution of life's problems, because it seldom makes for genuine and lasting satisfaction. Thus, the teacher who is disturbed by his realization that he has not won the respect of his students does not fool even himself when he says that any one can become a popular teacher by sacrificing his standards and by catering to the whims of a spoiled student body. He will be much happier and far more successful if, instead of trying to find suitable excuses for his unsuccessful teacher-student relationship, he analyzes

the situation and tries to see what he can do to improve it. The need for knowing one's self is not an invitation to brooding introspection. What is needed, rather, is the development of the habit of solving personal problems rationally, and of studying the causes of our own failures with intelligence and insight as well as emotion and sympathy.

The difference between a successful teacher and an unsuccessful one can be seen not only in their classroom procedures, but in their attitudes toward themselves and others. Let a teacher become aware of his competence, and his sense of assurance is bound to be reflected in his classroom performance. In this situation, as in so many others, it is difficult to tell which is the cause and which is the effect. Does he feel at ease in the classroom because he is competent, or is he competent because he feels at ease in the classroom? Certain it is that many teachers have not experienced as full a degree of security as they deserve, and that the accompanying manifestations of insecurity have in turn kept them from reaching their greatest efficiency.

The importance of this feeling of security may seem exaggerated, but many of the unpleasant aspects of the teacher's personality are the expression of his feeling of insecurity and inadequacy, either as an individual or as a teacher. The teacher who feels insecure is likely to interpret as a challenge many of the normal, but unpleasant characteristics of children. To such a teacher, a student's stubbornness seems to be a personal affront rather than an expression of the child's own emotional difficulties. This teacher is likely to regard a pupil's stupidity as an offense and not as a challenge to the teacher's professional ability. One writer refers to the "almost hysterical efforts of the teacher who misinterprets lack of interest as impertinence, and stupidity as misconduct. She then threatens, scolds, punishes, coaxes, drills, and coaches—in short, she does everything but teach."

The teacher who feels insecure is likely to be easily offended by criticism, whether from his colleagues or his superiors. Since he feels uncertain about his own competence, he resents any comment that is even mildly unfavorable. If he talks to others about his inadequacy or incompetence, it is usually reassurance that he wants and not criticism, whether it be

constructive or not. This explanation of the common trait of oversensitiveness to criticism can be verified easily. When an angry parent calls the teacher a murderer or a thief, the teacher ordinarily dismisses the outburst without much further thought. However, if she calls him a "half-baked psychologist," the chances are that he will be offended. We are hurt by epithets that touch our sensitive spots, that are true, or that we fear are easily accepted as being true. It is when a man is beginning to lose his hair and thinks he covers up the bald spot effectively that he is most easily shocked by being called "Baldy," a term that he would have dismissed laughingly a few years earlier. With the teacher who is easily offended, there is really little to be gained by telling him of the need for criticism. What he does require is satisfaction for his need for security. Once he feels emotionally secure, he will be able to interpret correctly the criticism directed at him.

It is well for both the teacher and the student to spend a few moments with Emerson's poem, *Fable*. You undoubtedly remember the little poem, which deals with the quarrel between the squirrel and the mountain. Feeling completely overshadowed by the very size of the mountain, the squirrel says, in part:

> "Talents differ; all is well and wisely put;
> If I cannot carry forests on my back,
> Neither can you crack a nut."

For our own emotional health, we must incorporate in our make-up the wisdom of Emerson's squirrel. Too many good teachers think only of the forests they cannot carry on their backs and forget that, figuratively at least, they can crack a nut. They are likely to think of all the things they cannot do rather than of their potentialities and achievements. With teachers like these, supervisors can perform a distinct service if they lead the teacher to a more realistic and more constructive view of himself and his professional achievements. It is unwise for the supervisor to interpret this suggestion as calling for flattery and empty praise. Teachers are too intelligent and too critical to be taken in by such a procedure. More harm than good will probably result from the error of praising a lesson the weakness of which is

apparent to both teacher and supervisor. However, there must be something that the teacher has to contribute to his class, or he has no business being there at all. Too often, supervisors take the teacher's commendable traits and practices for granted, and concentrate on his weaknesses. As a result, the teacher erroneously gets the impression that the supervisor is overcritical and is blind to the teacher's good points.

The illustrations that have been given thus far suggest the way in which a study of the teacher's personal adjustments helps to indicate what must be done if he is to modify his personality traits. However, not all of the teacher's difficulties arise from his personal life. Some of them are the result of his relations with his community and of the attitude that the community takes toward him. Though the average citizen is convinced of the importance of education in the maintenance of a democracy, it is generally of education in the abstract that he speaks. The teacher finds all too often that the respect that our citizens have for education does not determine their attitude toward him as an individual. He discovers that they are ready to pay him as little as they can and, when his contract expires, they are willing to appoint a native son in his place, even though the local candidate is inferior in experience and ability. In a wave of economy, public opinion seldom stops to differentiate between the amount of money paid to overburdened teachers and the salaries paid to the holders of political sinecures. The teacher must expect to hear his every innovation in curriculum and procedure derided as a fad and a frill, even when the change is the result of years of planning and experimentation. The world is full of civic organizations and pressure groups that are ready to tell the teacher what he must read, what he must believe, how he must behave, and even what kind of clothes he may wear. In a world that is alive with discussions of economic problems and with experiments in political and social reorganization, the teacher is generally expected to sit on the side lines and remain neutral, if not indifferent.

Even the likelihood that he will be allowed to hold on to his job is influenced by community practices over which he

has no control. In many cases a state law that supposedly grants tenure to all teachers after three years of successful service actually jeopardizes the teacher's economic security because he finds that the law is outwitted by the custom of having a teacher serve no more than two years in any one community. So personal a question as whether a woman teacher should marry or not is made a matter of public debate, and in many communities married women are expected to resign their positions immediately after marriage, even though such action is not required of any other profession.

Some of the unpleasant personality traits in a teacher may be part of his way of adjusting himself to a social situation that he cannot control. If a teacher in such a situation, then, becomes meek and colorless in the classroom, or if, on the other hand, he assumes a position of importance in the classroom that he does not enjoy in the community at large, we must understand the sources of the difficulty. We must realize that it is only by changing the community's attitude toward the teacher and his attitude toward the community that any lasting improvement can be made in his personality.

The survey of the background of personality has not been exhausted with the study of the teacher's personal life and his community relations. The question remains whether our profession itself may not be an important influence on personality development—whether there is anything in the teacher's daily work and contacts that may be responsible for the unwelcome traits.

It is unfortunate that, even within the profession itself, the status of the classroom teacher is held in undeservedly low esteem. There is a tendency to exalt the position of the supervisor and the administrator at the expense of the teacher. Is it not true that we expect the competent teacher to be promoted out of the classroom, and that there is the suggestion of professional failure attached to the experienced teacher who remains in the classroom? Can we wonder if teachers sometimes find that their position is not conducive to the development of wholesome self-respect? Teachers must be helped really to believe that education is the best

defense of our democracy and that in this process of education theirs is the key position.

Though it will be difficult to effect any sudden change in the community's attitude toward the teacher, there is much that can be done within the school itself to raise the teacher's feeling of self-respect. The teacher must be accepted by his supervisors not only as a trained subordinate, but as a professional colleague. Teachers' conferences must be used not as the means whereby the administrators tell teachers what is to be done, but as a forum in which problems of common interest are studied and discussed by professional men and women who are coöperating in a significant undertaking.

The results of classroom tests and examinations must be interpreted in terms of the student achievement they represent, and not as a measure of the teacher's industry and efficiency. The presence of problem children in the classroom need not be an index of the teacher's incompetence as a disciplinarian; it may indicate instead the necessity for a thorough study of these children and for a survey of the facilities that are available for helping them to improve their adjustments. As long as administrators persist in misinterpreting the results of classroom performance, teachers will succeed in offering presentable results, but they will have to ask questions that they know are too easy, they will have to drill on material that they know is insignificant or meaningless, and they will have to overlook instances of pupil maladjustment that they know warrant further study. And no teacher can long preserve his self-respect when he has to engage in practices he heartily disapproves of and yet dares not change.

We have concentrated here on the problem of the oversensitive teacher merely to indicate what can be done to bring about improvement in any single aspect of personality. We have used this trait to illustrate the kinds of question that must be asked when one tries to find the reason for the teacher's exhibiting this trait and to point to remedial procedures that are available. If we take any other personality problem—such as that of encouraging the teacher to continue his professional growth—we find that there, too, the three factors of personal life, social status, and professional recognition play their respective parts.

The desire for new experiences and for variety in the incidents of daily life is common to all people, including teachers. At first glance, the life of a successful teacher would appear to be a succession of new experiences, but this is the exception and not the rule. In many instances the teacher begins to sink into a rut as soon as he is appointed to his first position. As he continues term after term, presenting the same problems, using the same illustrations, following the same lesson plans, he finds his rut getting deeper and deeper. In teaching, as in every other worthwhile undertaking, it is impossible to live on accumulated capital. It is impossible for the teacher to stand still; as soon as he stops growing, he begins to decay.

A newly appointed teacher is likely to feel that he knows how to teach and that with only a little classroom experience he should be able to reach the peak of perfection. But he may not realize that all that his college courses in pedagogy can do is to teach him how to be an average teacher, a mediocre teacher. Whether he will ever become an outstanding teacher depends on his professional growth while he is teaching. It takes only a short time for a new salesgirl in a five-and-ten-cent store to become as good as the experienced salesgirl, but it is years before a teacher reaches his level of maximum efficiency. When the teacher finds that his days are too uneventful and that he encounters no new problems in the course of his teaching, he must take time to evaluate his procedures in order to see whether his professional growth has not stopped prematurely. One of the characteristics of the superior teacher is that he is never completely satisfied with his procedures, that he always sees the need for improvement.

As a writer pointed out some time ago, teaching is a dull job and an inspiring profession, but it can be inspiring only when the teacher senses the succession of challenges to his ability. When he has reduced his work to routine, he must see whether there are not better procedures for him to use. Questions of methodology, of curriculum construction, of the philosophy of education are of even greater significance to the experienced teacher than they are to the undergraduate student at college. If the teacher is constantly seeking to improve the educational process, if by continued study and

research he is steadily enriching his own background of knowledge and appreciation, and if he is ready to experiment with carefully considered departures from his past routine, he will find that teaching is far from being a monotonous job and that his profession offers many ways of satisfying his desire for new experiences.

Returning to the question whether the teacher's personality can be changed, we can agree on the answer: "Yes." But the process is by no means simple. Where the personalities of adults are concerned, it is difficult to discover the underlying causes of unpleasant traits and it is even more difficult to remove these causes and thus to change the adult's personality. Improving the teacher's personality is a difficult and a painful process, one that is not always successful. After all, one cannot change in a week traits that have been developed over a period of twenty or thirty or forty years.

May there not be another aspect of the problem of improving teacher personality? Can new entrants to our profession be so selected and educated that future teachers will have the kind of personality that is needed in the classroom? Here, too, the possibilities of a preventive program are far greater than are those of a program of correction. The key to the improvement of teacher personality is to be found in schools of education, where future teachers are now enrolled as undergraduate students. The school of education must select its students carefully and give them the kind of experiences that will make certain that the new teacher brings to the classroom not only a keen mind, a rich background, and skill in teaching techniques, but also a stable personality, one that will exert a wholesome influence on the personalities of his students.

GENERAL PRINCIPLES OF PSYCHOTHERAPY *

EDWARD G. BILLINGS, M.D.

Director, Psychiatric Liaison Department,[1] Colorado University School of Medicine and Hospitals, Denver

IN the past sixty years, during the development of our present genetic-dynamic psychiatry, many psychotherapeutic procedures have from time to time arisen. Some of these therapies, at one time or another considered of value in the treatment of personality disorders, proved worthless and faded from the pages of psychotherapy. Others, which at their inception seemed questionable, were ultimately validated by the tests of time and practice. But throughout this entire period, rational treatment of the psychopathological states has always arisen from, and in the end been reintegrated with, a sound plan based on the actually known and proven facts of personality functioning.

At the present time, when the broad vistas of biochemical, neurophysiological, and hormonal research are rapidly being brought within the field of vision of us who are personally and socially so hard pressed in our efforts to cure the mentally ill, we are again in danger. We who are engaged in clinical rather than in research psychiatry are in danger of being dazzled by some of the startling therapeutic innovations just now fashionable, such as convulsive-shock therapy, the administration of endocrine substances and autonomic hormones producing variations in biochemical ratios, and so forth—measures that are empirically proving of value in *some* of the more stubborn and inaccessible reaction types.

When I was asked to prepare a paper on psychotherapy, I debated whether to speak on some of these more recent innovations or just to discuss some of the general principles

* Read before the Missouri-Kansas Neuropsychiatric Association, Kansas City, Missouri, February 15, 1938.

[1] A division of the Department of Psychiatry, financed by a Rockefeller Foundation grant.

of psychotherapy. I decided to run the risk of being considered a skeptic and a conservative by talking on the latter.

At the University of Colorado Hospitals for the last three and a half years, we have been engaged in integrating the principles of psychobiology and psychiatry with those of general medicine and its various branches.[1] One of the most frequent and one of the most critical questions put to us by the non-psychiatrist has been, "Why is it that the psychiatrist is unable, or perhaps unwilling, to explain the general plan of therapy used in the management of psychiatric patients?"

This challenge we had such difficulty in meeting that we often found ourselves distracting the interested questioner with the dazzle of dramatic, but as yet inexplicable, procedures. I am inclined to feel that this was unsatisfactory to the man trained in conservative and traditional medicine, *and I am sure* it was disconcerting to us to find that we were unable to formulate a schema that could be used in the treatment of *any* psychiatric case. This led us to attempt to formulate such a design. The plan that I shall outline for you we have found to be conservative, safe, conducive to constant psychopathological research into the genesis and dynamics of the patient's illness, and—as proved in terms of time and outcome—applicable to the rank and file of pathergastic states. Yet at the same time it allows for the initiation of new and empiric psychotherapeutic experiments.

In psychotherapeutic practice, there are to my mind several prerequisites for success. In as much as psychobiology is still probably in little more than the infantile stage of its development, the physician must recognize the known facts for what they are and be able to realize that there are still more to be formulated. The first prerequisite, therefore, is the acquisition of a type of clinical discipline that will enable the psychiatrist to keep accurate records and maintain a position wherein he can test his therapy constantly, with incessant "whys," "hows," and "whats." This presupposes in the physician a thorough knowledge of personality organization and functioning; of racial, community, and family

[1] See "Teaching Psychiatry in the Medical School General Hospital; A Practical Plan," by Edward G. Billings, M.D. *Journal of the American Medical Association*, Vol. 107, pp. 635–39, August 29, 1936.

ideologies; and of ever-present and ever-changing socio-economic factors.

The second prerequisite is a healthy attitude toward the time factor in treating the psychiatric case. We still—and probably we shall continue to—include in our thinking and expectations some of the concepts that more properly belong to physical medicine. In so far as the time factor is concerned, psychopathological disorders, by their very nature, differ from the somatic disorders in that they are in general more extended. If an internist should expect a patient with typhoid fever to recover within two weeks, and as a natural result should try to hasten recovery, several new factors might enter the therapeutic problem. He would be unable to work with ease and therefore would work less efficiently; his patient would soon become subtly aware of his physician's attitude and so have an additional load with which to struggle; and, lastly, the physician, in his disappointment and resultant drive to force the issue, would be apt to overlook important features of the case, to come to rely too much on dangerous tricks, and possibly, in an indirect way, to influence the lay concept of the malady.

The third prerequisite is, of necessity, the acceptance of a broad definition of what constitutes treatment—a definition that can be accepted with ease and relative satisfaction whatever the state of our knowledge may be, and one that will include new data without requiring a complete change in the general schema.

How, then, shall we define treatment? Webster's International Dictionary probably offers as good an interpretation as we could ask for—viz., treatment is "the management and care of a patient or the combating of his disorder." In the University of Colorado Hospitals, we accept this definition as not only adequate to stand up under the critical gaze both of the psychiatrist and of the non-psychiatrist, but flexible enough to allow the psychiatrist to formulate a corrective program for *any case.*

In accord with this broad definition of treatment, we must accept as a psychotherapeutic postulate the fact that the treatment of a patient begins with the first interviews between physician and patient. The purpose of these preliminary

interviews is fourfold: (1) to arrive at an initial business and financial agreement; (2) to orient the psychiatrist as to the problem presented for treatment and as to a preliminary plan of therapy; (3) to orient the patient as to the nature and development of his complaint problem and to give him some idea of prognosis and a general concept of the constituents of therapy; and (4) to complete the final business arrangement.

In as much as it is essential that both patient and psychiatrist allocate a regular and specified time per interview to the work, and since both must realize their responsibilities and be able to plan ahead in an orderly and constructive manner, such planning very often involving questions of cost, it goes without saying that a preliminary financial agreement, covering the examination period at least, is of great importance.

If several periods are required for the fulfillment of these four requisites, the patient must understand the program so that he will wait agreeably for the final outcome. At the end of each interview, he should be given an explanation of the ground covered and some idea of what has been accomplished, as well as suggestions for investigations to be taken up at the next meeting.

No examination is merely that—it is, as we have already said, an instrument of treatment. Since it should thoroughly orient both psychiatrist and patient, it is important that the examination should be orderly and systematic. The complaint problem is elicited and then developed in relation to the present illness, care being taken to evaluate the setting in which it arose and the personal and extra-personal factors involved. After this, the personal and family histories are taken. Throughout this whole examination, since personality analysis may be necessary, it is well to sensitize the patient to any opportunities for further investigation as they arise. The initial examination is completed by a mental-status examination, physical and neurological studies, and any laboratory tests indicated. It is my personal opinion that if detailed analysis is anticipated, time will be saved by evaluating the patient's intelligence and his capacity for analytic and synthetic thinking.

Thus, at the end of the preliminary interviews, the physician should have become oriented as to the problem at hand and should be in a position to make a preliminary, but not a rigid or dogmatic, treatment plan in keeping with the patient's capacities. It is usually desirable to consider across-the-table discussions until one is sure of the patient's abilities. At the conclusion of these first interviews, the patient has, probably for the first time, been led, via the historical review, to an evaluation of his illness, and his interest and curiosity in doing something about the problem have been aroused. The average patient, if the physician has gauged his initial program carefully, has very likely by this time begun to visualize therapeutic opportunities as well.

These interviews should also be so conducted and concluded that the patient will not feel that everything to be accomplished is to be based on them. There may be psychological and other varieties of "skeletons" in the closet that have not yet been brought to light—in which case the patient might be skeptical of the program and be discouraged at the outset, or might feel that these "skeletons" are unimportant and never bring them out. Dragging material from the patient is usually contraindicated from the point of view of therapy, as it often causes an exaggeration of his symptoms or makes him antagonistic. The method here outlined has the further advantage that it aids the patient to realize the importance of patience in the work to come and increases his confidence in the examiner-therapist.

The physician has now attained a position in which it will be possible for him to change or to reverse his opinion without making the patient feel that he is uncertain or faltering.

The next step is to formulate what has been accomplished by explaining the patient's illness to him in understandable language, using as far as possible his own words, and at the same time desensitizing him to any shame he may feel in regard to his condition. In doing this the subject's personality assets and liabilities and the dynamic situational factors are pointed out to him, stress being laid upon those items that are most tangible and workable, in order to prevent any feeling of discouragement at first.

At the Colorado General and Psychopathic Hospitals, the

plotting of the life data of the patient on the "life chart" as devised by Dr. Adolf Meyer[1] has been extremely helpful in showing the patient more clearly the development of his illness. In conjunction with this, the tabulation of the examination findings according to the outline originated by Strecker and Ebaugh,[2] a modification of which[3] is given on page 31, has, in our experience, proved advantageous to the physician, not only in orienting him to the genesis and dynamics of the patient's illness, but also in providing him with a graphic method for evaluating treatment later.

The matter of prognosis and its implications is a decidedly difficult one in the light of our present knowledge of genetic-dynamic psychiatry, and it is especially formidable at this phase in the diagnostic-therapeutic project. The responsible relatives of the patient should of course be given the facts as they stand. Reassurance for the patient should be unstinted if he is in the throes of a major reaction, especially a depression or a state of anxiety, fear, or confusion. In general, in the psychoneurotic or minor reactions, with the exception of acute anxiety states and those occurring in individuals who show considerable positive suggestibility, it probably is well to make the patient feel his responsibility for getting well. Therefore, in such minor disorders, one must be cautious about giving too much reassurance in order to prevent the patient from "grabbing at a straw" and being too content to "ride along," leaving all the initiative to the physician. Also, if the patient is not too ill, he should be acquainted with his responsibility for abstaining from activities that interfere with therapy. The financial obligation should also be used, if possible, to increase the patient's spontaneity and constructive coöperation.

The rôle of the time factor in prognosis and treatment should be carefully explained. If the therapeutic period is rigidly fixed, the patient begins to anticipate results, becomes

[1] See the "Student Personality Study" used in Johns-Hopkins Medical School (mimeographed). A reproduction of the "life chart" is given in MENTAL HYGIENE, Vol. 15, October, 1931, between pages 800 and 801.

[2] See *Clinical Psychiatry*, by Edward T. Strecker, M.D., and Franklin G. Ebaugh, M.D. Fourth edition. Philadelphia: P. Blakiston's Son and Company, 1935. pp. 41–42.

[3] By Edward G. Billings, M.D.

UNIVERSITY OF COLORADO SCHOOL OF MEDICINE AND HOSPITALS
Colorado Psychopathic Hospital
and
Psychiatric Liaison Dept. of Colorado General Hospital

CASE

Main Facts

INDIVIDUAL MAKE-UP

A. Heredity

B. Constitution

1. Somato-biologic attributes
   a. Body type:
   b. General features:
   c. Physical defects:
   d. General health:
2. Intellectual attributes
   a. General level:
   b. Mental age: (I.Q.)
3. Emotional and primary temperamental attributes
   a. Instinctual drives:
      1. Self preservation:
      2. Race preservation:
      3. Herd:
   b. Emotional
      1. General emotional tone:
      2. Stability:
      3. Dissociation:
   c. Capacity and efficiency in controlling a and b

C. Developmental Factors

1. Age
2. Biologic
3. Cultural and ideologic (personal and familial)

D. Habits in Terms of Adjustment Capacity

1. Capacity for habit formation
2. Personal habits (patterns)
3. Social habits
4. Vocational habits
5. Response economy

REACTION TYPE

SITUATIONAL FACTORS (present)

A. Drives and Attitudes of External Milieu Resulting from Ideologies of:

1. Race
2. Group
3. Family

B. Psychogenic

C. Educational
Vocational
Recreational

D. Economic

E. Organic

F. Toxic
Infections
Traumatic

RECOMMENDATIONS RESULTS

narrow in his evaluation of progress, and as a result gets more tense, thus bringing in a new complication. If the period has to be extended, as is usually the case, he is apt to

plotting of the life data of the patient on the "life chart" as devised by Dr. Adolf Meyer[1] has been extremely helpful in showing the patient more clearly the development of his illness. In conjunction with this, the tabulation of the examination findings according to the outline originated by Strecker and Ebaugh,[2] a modification of which[3] is given on page 31, has, in our experience, proved advantageous to the physician, not only in orienting him to the genesis and dynamics of the patient's illness, but also in providing him with a graphic method for evaluating treatment later.

The matter of prognosis and its implications is a decidedly difficult one in the light of our present knowledge of genetic-dynamic psychiatry, and it is especially formidable at this phase in the diagnostic-therapeutic project. The responsible relatives of the patient should of course be given the facts as they stand. Reassurance for the patient should be unstinted if he is in the throes of a major reaction, especially a depression or a state of anxiety, fear, or confusion. In general, in the psychoneurotic or minor reactions, with the exception of acute anxiety states and those occurring in individuals who show considerable positive suggestibility, it probably is well to make the patient feel his responsibility for getting well. Therefore, in such minor disorders, one must be cautious about giving too much reassurance in order to prevent the patient from "grabbing at a straw" and being too content to "ride along," leaving all the initiative to the physician. Also, if the patient is not too ill, he should be acquainted with his responsibility for abstaining from activities that interfere with therapy. The financial obligation should also be used, if possible, to increase the patient's spontaneity and constructive coöperation.

The rôle of the time factor in prognosis and treatment should be carefully explained. If the therapeutic period is rigidly fixed, the patient begins to anticipate results, becomes

[1] See the "Student Personality Study" used in Johns-Hopkins Medical School (mimeographed). A reproduction of the "life chart" is given in MENTAL HYGIENE, Vol. 15, October, 1931, between pages 800 and 801.

[2] See *Clinical Psychiatry*, by Edward T. Strecker, M.D., and Franklin G. Ebaugh, M.D. Fourth edition. Philadelphia: P. Blakiston's Son and Company, 1935. pp. 41–42.

[3] By Edward G. Billings, M.D.

UNIVERSITY OF COLORADO SCHOOL OF MEDICINE AND HOSPITALS
Colorado Psychopathic Hospital
and
Psychiatric Liaison Dept. of Colorado General Hospital

CASE

Main Facts

INDIVIDUAL MAKE-UP

A. Heredity

B. Constitution

1. Somato-biologic attributes
   - a. Body type:
   - b. General features:
   - c. Physical defects:
   - d. General health:
2. Intellectual attributes
   - a. General level:
   - b. Mental age: (I.Q.)
3. Emotional and primary temperamental attributes
   - a. Instinctual drives:
     1. Self preservation:
     2. Race preservation:
     3. Herd:
   - b. Emotional
     1. General emotional tone:
     2. Stability:
     3. Dissociation:
   - c. Capacity and efficiency in controlling a and b

C. Developmental Factors

1. Age
2. Biologic
3. Cultural and ideologic (personal and familial)

D. Habits in Terms of Adjustment Capacity

1. Capacity for habit formation
2. Personal habits (patterns)
3. Social habits
4. Vocational habits
5. Response economy

REACTION TYPE

SITUATIONAL FACTORS (present)

A. Drives and Attitudes of External Milieu Resulting from Ideologies of:

1. Race
2. Group
3. Family

B. Psychogenic

C. Educational
Vocational
Recreational

D. Economic

E. Organic

F. Toxic
Infections
Traumatic

RECOMMENDATIONS RESULTS

narrow in his evaluation of progress, and as a result gets more tense, thus bringing in a new complication. If the period has to be extended, as is usually the case, he is apt to

become discouraged and therefore less capable of coöperating in the treatment.

Finally, the preliminary formulation should include a word of explanation about possible variations or phases in the manifestation of the illness during treatment, and also a clear-cut statement that the physician reserves the right to vary his therapeutic approach at any time.

With the requisites of the first interview or interviews fulfilled, and the groundwork of treatment laid, the succeeding measures can be instituted. In as much as treatment of the average psychiatric problem must include attention to innumerable factors, to disturbances of function on any or all of the levels of integration, and must be carried on over a considerable time, we have found it advisable for the therapist to maintain a discipline in his institution of treatment measures. As we have pointed out, this can be achieved by segregating the various procedures in certain categories, depending on the reasons for those procedures and the results expected from them. In general, therapy can be divided into *indirect* and *direct* measures, the two being carried on in close interrelationship.

INDIRECT THERAPY

Indirect therapies are the measures that are used in managing and correcting interfering *manifestations* of the disorder. In the treatment of the average patient, the psychiatrist, before beginning his therapeutic program, should carefully formulate these procedures and measures for what they are, so that the patient will not undervalue the importance of the need for treatment directed at the etiologic factors. For practical purposes the indirect therapies are best divided as follows:

A. *Symptomatic or Palliative Measures.*—These are intended to ameliorate and to control the more strictly anatomic and physiologic manifestations of the reaction, and therefore they are in the main purely medical-surgical methods. For example, they include the relief of pain, the treatment of sleep disturbances, the correction of any cardiovascular, gastrointestinal, respiratory, central-nervous-system and autonomic-nervous-system malfunctioning, and so on, that

may occur as concomitant repercussions of the personality disorder. Besides these more physiologically or somatically manifest symptoms, one frequently encounters such phenomena as hysterical blindness, deafness, aphonia, amnesia, hiccough, vomiting, and so on, which not only interfere with the patient's equanimity and capacity to assist the physician in the direct therapy, but may also even endanger his life through exhaustion, acidosis, self-injury, and so on. Here, either direct suggestion—in the waking state, in hypnosis, in drug hypnosis—or indirect suggestion—by means of the faradic current and other electrical and physical-therapeutic applications—is used in a palliative way.

B. *Supportive Therapy.*—This includes those measures that are necessary for the improvement of the patient's general biologic condition, such as procedures for the eradication of infections, for the correction of anatomic defects and dysfunctions, for the improvement of hemapoietic functions, and for the control of avitaminotic states, weakness, and so on. In general, except for the more specific medical measures indicated, nursing care and physical therapy are of outstanding significance here.

C. *Sublimative Therapies.*—Among these we find occupational therapy, recreational activities, work, and so on, measures designed to utilize the patient's interests and capacities in bringing about a better balance in living, thus making conditions more favorable for a therapeutic attack on the causal factors.

DIRECT THERAPY

Direct therapeutic measures are those integrants of the total remedial procedure that have to do with the economical management of the causal and dynamic factors at the root of the psychopathological disorder. Here again, for the sake of discussion, subdivisions may be considered.

A. *Management of the Dynamic Factors in the External Milieu.*—This part of the treatment, dealing with the causal-situational elements in the disorder, can be adequately carried out only if the psychiatrist is aware of, and has properly evaluated, the situation, after study of the patient's personality in terms of his environment. Here one has to recog-

nize and deal with the balance between rest, recreation, and work—with the budgeting of the patient's effort output in terms of *his* capacity, efficiency curve, and general satisfaction, as well as in terms of the expectation of others. Unhealthy attitudes, misconceptions, and ideologies of family, employer, school, and community are ever-present situational factors which require consideration and modification if the better physical, temperamental, and emotional functioning of the patient is to be promoted. Climate, geographical factors, working conditions, and the like, must be taken into account, and the patient guided accordingly. These procedures do not cure the patient any more than mere rest can cure acute appendicitis, but they do ameliorate and remove some of the dynamic factors involved in the production of the patient's illness—factors that often, if not attended to, may have much to do with the difficulty experienced by the patient in solving his problem of maladaptation, or even his failure to solve it. In other words, these therapeutic measures, either *alone* or *together,* are not adequate in treating the average psychiatric problem, since they do not deal with the causality lying within the "internal milieu" or personality matrix of the patient.

B. *Management of the Personality-Determined Factors.*—In psychotherapy or the treatment of the more strictly personality-determined factors in the situation, the problem is that of understanding and dealing with disturbances in the patient's mentation and in his personality development and performance. To be more specific, the therapist here is concerned with the straightening out of memories, anticipations, ideas, misunderstandings, various types of understanding, uneasy feelings and hindering moods, and the various problems in the patient's utilization of his assets and capacities—in short, with anything that is giving rise to attitudes, reactions, and actions that interfere with satisfactory, healthy, and efficient functioning.

Such treatment naturally varies with the personality of the patient, the type of illness from which he suffers, the physician's personality and training, and such impersonal factors as time, money, and so on. The methods followed may be roughly grouped under three headings: (1) sugges-

tive measures; (2) personality study, or analytic synthetic procedures; and (3) reëducation.

1. *Suggestive therapy* is always used to some extent in the form of reassurance, persuasion, and indirect and direct suggestion. These measures are utilized from the moment the patient confides the story of his complaint to the physician up to the completion of the examination, the formulation of the problem, and the treatment period. Direct suggestion is of special value in some of the minor or psychoneurotic reactions and is instigated when the patient is either in a state of hypnosis or drug hypnosis, or in a waking state.

2. *Personality study,* consisting of analysis and synthesis of the personality attributes—particularly the assets and liabilities involved in the production of the patient's illness—is in the majority of cases the most important part of the whole treatment program. For this analytic-synthetic procedure, there are in use to-day two main methodologies—(a) psychoanalysis, as developed by Freud, and (b) distributive analysis, the method of Adolf Meyer. I shall limit my remarks to a brief elucidation of the latter procedure—*distributive analysis.*

"Distributive analysis," as originally introduced by Adolf Meyer, is, according to Diethelm,[1] the "most natural approach to the correction of personality difficulties on a psychobiologic basis. . . . The goal of treatment is a synthesis of the various factors and strivings which will offer the patient security." The following outline, formulated by Dr. Meyer, gives the main points in this procedure:

OUTLINE OF PERSONALITY STUDY

I. General personality survey (jobs, hobbies, activity with family, friends, religion, education, and politics as examples of performance; type of rest and satisfaction obtained after effort).

II. Special analysis of the psychobiologic assets (intelligence and memory functions, action tendencies, emotional rises and balance).

III. Range and fluctuation of fitness with regard to work, play, rest, and sleep.

IV. Social relations in family, and the relative rôle of self-dependence and social dependence.

V. Sex development.

[1] See *Treatment in Psychiatry,* by Oskar Diethelm, M.D. New York: The Macmillan Company, 1936.

VI. Synthesis and balance of personality (personality type, rôle of less directly accessible influences, the position of any "unconscious" determiners).

VII. Difficulties and handicaps.

VIII. Specific disappointments and reactions to them.

IX. Assets and tendencies, favorable and unfavorable, traced to heredity, special sense-organ development of motor abilities, etc.

X. An enumeration of the events, experiences, and situations in life which constitute special dynamic complexes or determining tendencies, in the form of an index of the significant results of the personality study.

The treatment is carried on by means of confidential interviews in which the physician takes the lead and directs the discussion. He raises topics or formulates questions designed to assist the patient to an understanding of his personality capacities and incapacities. The patient's symptoms are considered and evaluated; the problems recognized as significant by the physician are talked over; and the patient's memories, his imaginations and anticipations, his urges and strivings, his attitudes toward these drives as well as toward the past, the present, and the future, and his actions and reactions to existing situations—personal, interpersonal, and more strictly situational—are thoroughly discussed. In this way the patient is methodically guided through an analysis of his conative and cognitive attributes and functional characteristics, his effective and diffusely automatic regulative functions, the range and fluctuation of his fitness and efficient-economical performance, the familial and social influences and factors that have made up his environment, and his sex development and functioning as manifested in the various situations and under the manifold circumstances of everyday life.

Thus, the patient, through a systematic and controlled process of ventilation which objectifies his problems, becomes affectively desensitized to certain topics and factors. At the same time he is led to find ways and means of developing modifications or amplifications of his utilization of past experiences, of attitudes and activity pertaining to the present, and of ambitions and anticipations of the future, and more efficient self-management in his present milieu, thus synthesizing the facts unfolded in the analysis into a working economy of a healthy and satisfactory nature.

The physician must plan the discussions in terms of content and a method of approach in accordance with the

patient's capacity, the type or phase of his illness, and his general circumstance. The interviews should be timed as to frequency and duration in such a way as to fit the program to the individual patient's needs and abilities and still be flexible enough to be altered to meet the immediate status of the patient and his disorder at each treatment period.

Often certain life material of the patient that is necessary for the continuation or completion of the treatment is more or less inaccessible because of the patient's sensitivity about discussing the facts, or because he has forgotten them, or because, if he should be allowed to divulge them, he would be upset to such an extent as to jeopardize his progress. In cases of this kind it often becomes mandatory upon the physician to utilize a more circuitous methodology for orienting himself and the patient to the factors that require understanding and management. For this the Jung association test and the association-motor experiment as developed by Ebaugh,[1] the free-association technique, with or without hypnosis, or the Rorschach test, are often of great value in filling in the factual gaps. As the gaps are so bridged, the material is then used in direct discussions with the patient, being amalgamated with the basic plan.

Occasionally one finds a patient who can think in a more analytic-synthetic way if his personality problems are objectified through graphic means. Here, a written personality study, with use either of the Meyer outline or of that formulated by Ebaugh and Billings,[2] gauged and modified to fit the personality of the patient, is advantageous. The facts as they are elucidated in writing are then discussed so far as they can be adapted to the broad treatment procedure.

At the termination of each psychotherapeutic discussion, the psychiatrist must formulate as before what has been accomplished during the meeting, tying it up with preceding discussions and paving the way for those to come. He does this by direct explanation, using as far as possible the patient's own words, or by offering the patient a hypothetical

[1] See "Association-Motor Investigation in Clinical Psychiatry," by Franklin G. Ebaugh, M.D. *Journal of Mental Science* (London), Vol. 82, pp. 731–43, November, 1936.

[2] See *Outline of Psychobiology*, by Frankin G. Ebaugh, M.D., and E. G. Billings, M.D. Philadelphia: W. B. Saunders Company, 1938.

question to be considered in the interim between interviews. At the same time the therapist gives the patient any advice indicated, modifies or eliminates indirect measures, or varies the handling of the situational factors—always explaining, if this is at all possible, what is being done and why.

This concluding period of each interview is also utilized for evaluating the patient's progress or persistent difficulties in terms of the original complaint. Thus, in each therapeutic discussion, the goal is that of synthesizing the various factors of personality and of the external milieu into a summary that offers the patient security, an increase in spontaneity, and concrete facts with which to guide and control his future performance.

In general, throughout the program as outlined, it is of great importance that the patient should not be overwhelmed with too much or too difficult material at one time; that appropriate therapeutic rest periods be allowed when indicated; and that the physician feel free to alter his planned therapy to meet any exigency and to avoid therapeutic difficulties that might arise in the future.

The patient's attitude and reactivity to the therapy must be constantly scrutinized and evaluated. For example, if the patient cannot or will not coöperate because of his personal rigidity or resistance to the procedure, this fact is brought to his attention and discussed in the hope of modifying the difficulty. If symptomatic, supportive, sublimative therapy, or the management of the situational factors as such, ameliorates symptoms to the extent that the patient loses interest in or incentive to continuing the treatment advantageously to himself, it very often becomes necessary to change such therapeutic measures or to make less use of them in order to reorient the patient to his actual status by allowing the symptoms to come to the fore again.

Finally, the psychiatrist should not permit himself to be led by interest in research to follow his treatment through to a "bitter-end analysis." The object of the treatment is to return the patient to his usual, or to a different, but more logical, status in life—not to create a dependent or an over-self-analytic personality, with diminished spontaneity. The analytic-synthetic treatment should be brought to a close as soon as possible.

3. The conclusive step in the treatment has to do with the *reëducation and readjustment* of the patient to whatever level of life is advisable and practical. His readjustment is the final proof of the efficiency of the physician's therapeutic program.

Very probably my failure even to mention some of the more recently heralded psychotherapeutic measures—such as insulin-shock, metrozal-convulsive, and prolonged-sleep therapies—in this discussion of the general principles of treatment has been conspicuous. The prolonged-sleep procedures I feel are beneficial only in that they create a situation wherein patient and physician can meet unimpeded on a common ground for the promulgation of basic psychotherapy. The effectiveness of jeopardizing and possibly assaulting dangerously the entire psychobiological status of the patient by means of convulsants is very difficult for me to evaluate. The facts so far known concerning convulsive therapy are scant, but what few there are seem to indicate that results are secured through the production of sudden and temporary neurophysiologic and biochemical changes which permit a reintegration of the various personality functions into a more natural and normal economy.

We should all be heartily in favor of controlled convulsion-producing measures as long as they give results and provided they do not in time give rise to worse disorders of the personality. Let us not, however, forsake the multitude of facts already known about psychobiology and psychopathology in the hope of solving the disorders of "man-function" solely with a needle and a syringe.

In concluding this attempt to outline a schema of the general principles of treating personality disorders, I should like to take the opportunity to express my conviction that as we make, via the test-tube, electrical, and syringe routes, new, alluring, and no doubt very profitable excursions into the functions and malfunctions of man, we must at the same time give constant and ever more vigilant attention to the common psychobiologic phenomena so close to us and yet so frequently neglected—namely, the facts concerning the *well man* as a totally and mentally integrated person living in a complex and ever-changing social system.

A PSYCHOLOGIST IN A UNIVERSITY NURSERY SCHOOL *

HARRIET E. O'SHEA

Associate Professor of Educational Psychology and Nursery-school Administration, Purdue University, Lafayette, Indiana

A UNIVERSITY nursery school, such as the one at Purdue University, is a complex affair. There are, first, the actual schools which the children attend—at Purdue, one group of sixteen children between the ages of two and four, and another group of twelve children between the ages of four and five. These schools consist not merely of the children, but also of the parents and the homes of these various families. It is particularly apparent with such young children that the relationships between them and their fathers and mothers are among the most potent factors in their lives in the shaping of their personality traits. Consequently, a nursery school is as much concerned with parents as with children.

The staff of a nursery school studies all the possible ways in which it is or can be in touch with parents—when the parents bring the children in the morning and get them at noon; when the staff calls at the homes many times during the year; when parents visit the school; when parents and staff members have special interviews; when the parents come together in a study group; when parents and teachers meet at some general community gathering, such as a lecture, a party, church, and so on.

The Purdue University Nursery School is used also by various psychology classes. It is used for a course in child psychology in the junior year, for the observation of various characteristics of children. It is used by students in their senior year in a required course in child care and development which includes two laboratory periods a week in the

* Read at a meeting of the Indiana Association of Clinical Psychologists in conjunction with the Indiana Conference on Social Work, Indianapolis, October 2, 1937.

nursery school. It is used by graduate students who are learning to be nursery-school teachers. From time to time, research studies are conducted in the school. Throughout the year many persons who have no affiliation with the university come to observe the nursery school. Each of these groups—as, for instance, the student teachers—presents interesting problems and opportunities for psychological work. The present discussion, however, will concern itself with the two central enterprises of the nursery school—the development of the children and coöperation with their parents.

The function of a psychologist in a nursery-school situation is to recognize and to watch for indications of all sorts of situations calling for psychological understanding that might otherwise escape the attention of the teaching staff or that the staff might fail to understand. It is then the further responsibility of the psychologist not only to suggest measures for the immediate handling of the situation, but also from week to week to help the staff become themselves more and more competent psychologists.

It is the conviction of psychologists who are working in the nursery-school field that the study of young children and the discovery of the most constructive ways of handling them may ultimately supply some of the most significant answers to the problems of mental and emotional difficulties in adolescence and in adult years. It may be possible, as one works with two- and three-year-olds in the nursery school and in their homes, to detect behavior that, if unchanged, would lead to mental or emotional difficulties later on. It may be possible to analyze the causes of this behavior in two- and three-year-olds and to discover from these investigations how to direct parent-child relationships and the general daily experiences of the child so as to prevent the appearance of such premonitory behavior in young children and to reëducate the parents and the child if unfavorable behavior has already made its appearance.

A few examples may serve to illustrate the kind of thing that a psychologist can do in a nursery-school milieu. One child comes to mind who had been in the nursery school for a year before the psychologist came upon the scene. The boy was about three years old when the psychologist first began to

observe him. The staff had found him, in an informal sense, a troublesome child. He was excitable and tended to attack the other children, pushing them, hitting them, pulling their hair, and so on. Early in this school year he had begun to spend most of his time sitting on a certain hobbyhorse. From half to three-quarters of the nursery-school morning he would spend on this hobbyhorse, sitting quietly or perhaps bouncing a little.

The staff had welcomed this retreat of the child's because of the relief that it gave to the other children. It will, however, be immediately apparent to any child psychologist that this retreat had serious implications for the future, the most immediate issue being that the child learned very little day after day sitting on his hobbyhorse, whereas he had the opportunity and was under the necessity of learning many useful things as he participated hour after hour in the life of the school.

The psychologist immediately decreed that no matter what happened to the rest of the nursery school, no matter what problems in administration might be precipitated in protecting the other children from his violent advances, every effort must be made to tempt the child off his hobbyhorse and to keep him active in the ordinary life of the school. The graduate students in the nursery school were then given the task of observing and analyzing the situations in which this boy hit other children, in as much as this offered an important opportunity to learn how to study child behavior.

With the help of the staff and the psychologist, they gradually came to recognize the fact that there were three different types of situation in which this boy hit other children. In many of the situations in which this behavior occurred, he was, apparently, thoroughly friendly and social, but merely so ignorant and clumsy that he knew no other way of expressing sociability and of inviting social intercourse. On other occasions, he would be intensely absorbed in endeavoring to do something with or without other children, and when he could not accomplish what he had started or when something went wrong, he would apparently go completely to pieces. His hitting and fighting on such occasions was evidently a wild

expression of his utter hopelessness and his complete lack of belief that he could solve the problem.

In the third type of situation the hitting was used purely as an exploratory and investigative technique. This the child himself neatly explained for the staff on one occasion when he started to push a little girl in the cloak room. The teacher explained that Mary did not like to be pushed, but would prefer to have Bob talk to her or hand her her coat. He then asked whether he could push the radiator. The teacher told him that that would be all right, and he went to the radiator and attempted to give it a hard shove. Returning to the teacher, evidently to point out to her her mistaken idea as to what was worth doing, he said, "But the radiator doesn't do anything when I push it."

In helping this child, it was evident that the staff must know with certainty which type of experience he was going through when he started to hit the other children. It would then be possible to offer the kind of support and assistance that would enable him to institute more successful and more constructive behavior.

Another child in need of special attention was a capable boy who was admitted to the older age group at the age of four. His younger brother was taken into the younger age group at the same time. The family felt that the older boy's greatest difficulty—and their greatest difficulty—was his almost continuous sucking of his thumb. They declared that they had done everything that they could possibly think of to eliminate this habit and still the boy continued to suck his thumb.

The staff found him a highly distractible child. He was quite obviously keen mentally, but he flew from experience to experience, grabbing up toys and trying to hold them as his armful grew, talking excitedly with one teacher and then with another, rushing to the window to look at things, tearing back to do some building with blocks, rushing from there to the sand pile, and so on. The psychologist was fairly sure from the start that this was an evidence of past overdirection or some other type of deprivation in play experience. Exactly as the staff anticipated, the child's purposes became more constant, his excitability less, and his constructive results much greater as week after week of nursery-school experience

proved to him that no one was going to snatch things when he had them, that he would find things where he had left them when he came back to them, that every one was perfectly willing to let him have as many experiences as he wished or to elaborate them as he chose, and so on.

Meanwhile, as the child's play experience grew more steady and more reasonable, he sucked his thumb less because of the simple fact that he needed his hands for other purposes. However, the thumb-sucking did not decrease as rapidly as his constructive play experience increased, indicating that there must be special causes for a habit so rigidly established.

It was discovered that the family were unusually intense in their desire to stop the thumb-sucking and had been so for two or more years. Some of the boy's relatives had attended West Point; if this child sucked his thumb, it would push his jaw out of line, and he—all this when he was two, three, and four—would not be admitted to West Point if his jaw were not perfectly shaped.

The family gave a history of working with the thumb-sucking which included a period of a full year when the child's arm was kept in an elbow cuff day and night except for brief intervals of dressing, and so on. It was quite evident to the psychologist that at no time was the child's coöperation secured in the use of the elbow cuff. This device had simply been imposed upon him. He had never been able to reach the point where he wished to stop sucking his thumb and where the project was definite enough in his own mind so that he welcomed the assistance of the elbow cuff. In fact, it seemed fairly clear that, among other results, the child had been thoroughly frightened and convinced that he never could stop sucking his thumb. It was certainly the conviction of his parents that they were fighting a hopeless, losing game, their failure and the child's failure ultimately to be penalized with the worst calamity of all—his exclusion from West Point.

It was striking also that the mother apparently at no time had felt sorry for the child or reluctant to impose this severe physical restraint upon him. (Various other methods had been used also, such as aluminum mits, quinine on his thumb, and so on.) Instead, she had enforced it with Spartanlike severity and apparently felt only irritation and frustration

that she had not achieved the desired result. The father seemed a little more regretful that life had been so hard for the boy.

The staff quickly learned to be very sparing indeed with suggestions to the family about how to handle the child, because any suggestion was put into effect with military thoroughness, the family, from their point of view, wishing to do everything possible to run a model home. The results, of course, were vastly different from what the staff desired.

One of the home projects on which the parents had been working, the failure of which greatly disturbed them, was that of developing "brotherly love" between their two young sons, who were two and a half and four years old when the psychologist first saw them. The family's method of developing brotherly love was to throw the children together in every possible way. They slept in the same room, had one closet, one bookcase, one set of toys, and even one simultaneous daily bath, upon which occasion they were both put into the tub together. No faintest notion of the different requirements of the two mental age levels had entered the heads of the parents. Consequently, they were totally unaware of the fact that the younger child spoiled the play of the older one and irritated him, and that the older one overstimulated the younger one, deprived him of play experiences, and so on.

As the staff worked slowly and carefully with the family, bit by bit suggesting concrete ways in which to separate the children, protecting each from the other and insuring each his own independent chance for experiences, harmony began to appear between the two boys from what seemed to the family the paradoxical situation of their being separated. The parents again followed out every direction with military precision, but the staff on their side were exceedingly careful to make only the simplest and most concrete suggestions which no thoroughness of execution could spoil.

The history of the mother, which the staff learned gradually, was that she was the youngest of several sisters. She had had a nervous breakdown in her early teens which had elicited much sympathy from her family. She had obviously been treated as the flower of the family. She had had an interesting, successful, though brief, professional life as a

teacher before she had married. Since her marriage, she had had none of the satisfactions she had been accustomed to and had done all of the things she had always disliked doing, such as house-cleaning, cooking, making clothes for her children, being ill before her children were born, and so on. Quite obviously and simply, although she had in no way analyzed or verbalized the situation, her children were an outright frustration and burden to her.

In the course of their other enterprises with the family, the staff contrived to ease the mother's burdens in various ways and set about securing for her periods in her daily or weekly life when she would be perfectly free from her children and at liberty to do some of the things that she liked to do. Although the staff were in touch with the family only about a year and a half, there seemed to the psychologist to be signs that the mother was beginning to relax a little and to have a slightly warmer and more pleasurable contact with her children as they began to "behave better" and as she had more freedom from them.

A specific illustration of the kind of manifestation that a psychologist can and must understand, which ordinarily would escape detection as a matter of significance, occurred in connection with the parents themselves in the first year that the psychologist was in the nursery school. The school had been operated a few years without adequate provisions in the way of staff, space, and so on. When money was secured to build the organization into one prepared really to administer a constructive mental-hygiene program, it became possible to consider the education of the parents as a major project of that program. Prior to that time there had been nothing in the way of parental education that the single nursery-school teacher had been able to do except to arrange for monthly lectures by other members of the faculty to the parents' group. Early in her first year the psychologist planned that these lectures to parents should stop and that by the middle of the year there must be a parents' committee which would gradually be educated to take over the meetings and transform them into whatever kind of group deliberation the parents might want.

The first parents' committee started out with many misgivings and forebodings. The psychologist and the staff under-

took to build the skill of this committee exactly as it would undertake to develop the ability of a child. Through conference and discussion the committee reached the point where it decided to interview the other parents about what they would like to take up at the parents' meetings. They asked for a written statement of problems that could be investigated within the group. One problem and one only came in. This aroused the committee to greater determination to get results. They said they were sure that their fellow parents had a lot of problems in mind and they could not understand why these were not turned in. By judicious conference, the idea was gradually developed in their minds that they might go around to the other parents and find out personally what problems they would like to have considered. This was done.

They came to the psychologist's office to tell her what, as a result of their conversations with various parents, they had selected as the most important matters to be worked upon. If the psychologist and the nursery-school staff had had no other way of knowing that presenting formal lectures to parents was a poor procedure, this committee report would have settled the matter in brilliant fashion. The chairman of the planning group was the mother of a child whose intelligence quotient was 170. It was she who formulated the question which she felt was the most urgent of all and which the whole committee agreed was the most outstanding problem that had come up in all of their discussions. The problem was, "How can parents avoid realizing how inadequate and unsuccessful they are in handling their own children as soon as they get into touch with experts who know all about it?"

The startling significance of this confession of deep discomfort merits profound thought on the part of clinicians. It is at one and the same time a demonstration of the great feeling of inadequacy and the sense of past failures that parents have in dealing with their children and of the almost inevitable feeling of insecurity and uncertainty with which they surround their children in dealing with them. (Unquestionably other experiences of parents, aside from their incompetence with their own children, enter into their expectation that what they do with their children must be wrong.) Probably no matter what a parent does in his relationship with his child, it

is more reassuring and more wholesome for the child if he does it with assurance, confidence, and decision.

One must observe the implication in an "expert's" standing up before a group of parents and telling them how to handle their children. The only possible implication, and the one that obviously gets across to the parents, is that they themselves are not very good and do not know so much as the expert. In the nursery school in question, this entire conditioning of parents was reversed. No one has addressed that group of parents in the past five years. Anything that is worked out for group discussion has to be worked out by the group itself. It is the belief of the psychologist that this must inevitably build up the opposite conviction in the parent's mind—namely, that having to think a problem out for oneself and doing so is, *ipso facto,* proof that one can solve the problem. It is the same way in which one builds confidence in a child. Each child obviously is capable of doing what he has done.

There are occasional instances of discomfort observable still in the group of able parents in this particular nursery school, but never since that time has there been any evidence of such wide, universal fear of their own job as was expressed by the brilliant chairman of the first group. On the contrary, there seem now to be some serenity and some confidence and optimism in their facing of the daily experiences of developing children. There have been, of course, besides the issues connected with the group meetings, many other factors aimed at developing confidence which the staff has promoted constantly, but this episode will serve to illustrate the care and thought that a psychologist must give to apparently trivial aspects of the total situation, which may have definite and important bearing upon the attitudes and behavior of the parents and the children involved.

It is the business, then, of the psychologist to recognize such things as the fact that the question whether a group of parents shall have a lecturer or whether they shall work out discussion issues themselves may actually, literally affect the personality traits that their children will display as they enter adolescence ten or twelve years later. The responsibility of the psychologist is to recognize and analyze such issues and to provide for their correct, constructive handling.

THE CHILD REVEALS HIMSELF THROUGH PLAY *

THE METHOD OF THE PLAY INTERVIEW

JACOB H. CONN, M.D.

Children's Psychiatric Clinic of the Harriet Lane Home for Invalid Children, Johns Hopkins Hospital, Baltimore, Maryland

WHAT we are pleased to call modern psychiatry first came into existence when the patient was invited to participate in his treatment. The psychiatrist learned to listen, and became more than a physician to a system of organs and tissues. He became a fellow human being who was willing to engage in a give-and-take personal relationship. In this way he was led to a growing interest in a live person who had complaints and a need to talk about them. The attitudes and feelings of the patient to those about him became subjects for consideration, as well as the complaints of those in the environment who had been disturbed by his behavior.

For a number of reasons, studies of the personal life of the child have lagged behind those dealing with adults. In contrast to the new attitude in the realm of adult psychiatry, it was considered proper, in speaking of children, to repeat the time-worn saw, "Children should be seen and not heard." The privilege of self-expression was reserved by adults for adults only. Children were not supposed to have "serious" problems. Childhood was spoken of as the Golden Age, a period free from worry, insecurity, and fear.

But what are the facts? How can they best be obtained from the only one who knows—the child himself? Any direct conversation with a child upon personal topics is difficult—indeed, at times impossible. Is it possible, for example, to get a five-year-old child to tell how she feels about her parents or about the coming of a new baby, when she knows what every one *expects* her to say?

Fortunately the key has been found to the locked door that has shut off our understanding of what the child is really

* Presented at the Annual Meeting of the Children's Aid Society of Western Pennsylvania, June 11, 1937.

thinking and feeling. It lies in the utilization of the normal play interests and needs of the child. Parents and others who have had the opportunity to observe children playing with dolls have heard them repeat the scoldings that they have received, as well as their own desires and hopes. A glimpse can thus be obtained of the personal life of the child. In this way the parent-child relationship also can be observed in the process of its earliest formation.

It has been possible to utilize these natural tendencies to self-expression in experimental play situations. In contrast to other play methods, the play interview that is described in the following studies has been made part of a general personality survey that includes a review of the biographical material, an investigation of school and home situations, physical and psychometric examinations, and other special studies, as indicated in each individual case. In addition, and along with the play studies and treatment, social-service aid is often enlisted, school adjustments are made, and the attitudes of parents are investigated and modified in order to meet the needs of the individual child.

The play interview is included in this plan of treatment as one of many procedures. It serves to supplement other methods, contributing material that deals with the personal, emotional, and imaginative aspects of the child's behavior.

During each play contact, the child is treated as an equal whose opinions are respected and listened to attentively. The child's responses are accepted at their face value. No attempt is made to interpret the play material to the child. Neither is any preliminary attempt made to bind the child to the physician by ties of gratitude for favors granted and the need for adult protection. In each case the child's complaints are made the focus of the therapeutic situation. The child comes to the physician because he is frightened, nauseated, or complaining of pain. How can he best be helped and be taught to help himself? How much has *he* contributed to his personal discomfort? The question of personal responsibility and the acknowledgment by the child of the rôle that he himself plays in the total situation comes up repeatedly in this method.

The physician assumes the part of the friendly, informed

adult, who is naturally curious to know *why* the child makes the doll do and say what it does when it does. The procedure provides a number of opportunities for the child to express his feelings and thoughts through the medium of the dolls, as if they were responsible for all that was said and done. Thus the child, as an impartial spectator, can view objectively what is going on, at the same time that he is actively participating in an intimate discussion of his own attitudes. It is not the child himself, but the doll, who is afraid of the dark. It is not he who is jealous or hates, but the doll character. Therefore, he can describe the motives and imaginations that may explain the doll's behavior, and consequently his own. Toy furniture and dolls, representing various characters—parents, teachers, siblings, and so on—are used during the play session, and various "sets" are arranged by the physician as upon a miniature stage. In this manner life situations are duplicated and such behavior patterns as temper tantrums, night terrors, disturbing scenes at the dinner table, are reënacted through the medium of the dolls.

The child also is given an opportunity to play freely with the dolls, but the emphasis in this procedure is placed upon planned play situations which may be repeated as frequently as desirable. Such problems as car sickness,[1] fear states,[2] sibling jealousies, reactions to parental under- or over-solicitude, and, more recently, the sex attitudes and sex awareness of the child,[3] have been studied in an unbiased, self-critical manner by a series of repeated play experiments.

The case material that follows has been collected since 1933 by methods devised by the author at the Children's Psychiatric Clinic of the Harriet Lane Home, Johns Hopkins Hospital.

The problem of body complaints for which no physical basis is found is exemplified in the play material presented by the first case. Barbara, six years old, a self-assertive, red-headed child of above average intelligence (I.Q. 116),

[1] See "A Psychiatric Study of Car Sickness in Children," by Jacob H. Conn, M.D. *American Journal of Orthopsychiatry*, Vol. 18, pp. 130–41, January, 1938.

[2] See "The Child Speaks to the Psychiatrist; An Introduction to the Method of the Play-Interview," by Jacob H. Conn, M.D. *Occupational Therapy and Rehabilitation*, Vol. 17, pp. 231–44, August, 1938.

[3] A preliminary report on this study is to appear in the January, 1939, issue of *Child Study*.

was referred because she was keeping the family awake by screaming that she had an earache. Two weeks before the onset of the "pains," the patient had had a tonsillectomy performed and, two days later, the crying spells had begun. Several physical examinations had revealed nothing to explain why this child was upset.

Barbara was the daughter of an oversolicitous mother and a doting father. She had been the center of attention until the baby came, ten months before she was brought to the clinic. The patient had been irritated by the attention paid to her baby sister. She had been heard to say, "You don't pay attention to me, only to the baby."

Thus we had all the factors for a jealousy and attention-getting reaction in a spoiled, self-assertive youngster. But was this what the child was thinking? There was only one way to find out—to let the child herself tell us. A toy bed with a girl doll in it was set before the patient. Barbara was asked: "What happens?"

A: Her throat hurts her. It really did at first. . . . Now she gets up and cries every night.
Q: Why does she cry?
A: She wants her mother to come in.
Q: If this girl cries, what is going to happen?
A: She wants her mother to stay with her.
Q: Why does she cry?
A: She wants to make her mother sick and die. She'll go to heaven.
Q: Then?
A: She'll have no mother.
Q: Does her throat hurt her bad?
A: No.
Q: Then she is hollering for nothing?
A: Yes. She wants to worry her mother.
Q: Now *you* know that the little girl is trying to have her own way.
A: You're right. I am not going to cry.
Q: Are you going to sleep alone?
A: Yes.

Three days later the mother reported that Barbara had slept alone without screaming for the first time in two weeks. She had referred to her earache only when she had been left out of the conversation.

During this second session, the patient volunteered the remark: "You know what I did? I slept all alone."

Q: Why?
A: 'Cause I wanted to. My throat didn't hurt at all.

The problem of Barbara's contrariness in eating and dressing was taken up in this session. A little girl doll was seated at a toy table upon which were placed several toy dishes.

Q: How does this little girl eat?

A: She doesn't care. She takes her fingers and puts it in her mouth and licks them, then walks away from the table. She tells her little sister not to eat anything.

Q: Why does she do that?

A: She wants to show her mother how bad she wants to be.

Q: Why?

A: She is trying to worry her mother.

Q: Why?

A: So her mother [who has partially grey hair] will get grey hair and go to heaven. So she won't have a mother. Her father will have to get a nurse. You know my grandfather died of pneumonia.

Q: Now *you* know why you don't eat with a fork?

A: I want to worry my mother sometimes. She says she will go to heaven if I keep on worrying her—so I try to worry her.

A mother doll was placed beside a little girl doll. The patient began as follows:

"'Doesn't our daughter eat terrible?'

"'You are right, she does eat terrible. We got to go down and watch the children, how they eat . . .'

"Now she doesn't eat with her fingers. She doesn't want to be a bad girl."

Q: Here is a mother and her little girl. The mother gives her a dress to wear.

A: The mother wants her to wear a brown dress. She says, "No, I want to wear my green dress." She is trying to worry her mother sick. She wants to let her mother go to heaven. Then her daddy will have to get a nursie.

Q: Now this girl can be a good girl. She knows why she wants another dress. Now you are going to be a good girl.

A: 'Cause I don't worry my mother sick. I don't want my mother to go to heaven.

Q: Why were *you* bad?

A: I wanted my mother to go to heaven.

Q: What is heaven?

A: Where they keep all dead people.

Q: And dead means . . . . ?

A: Their eyes are shut and don't open.

The next week, during the third session, her mother reported that Barbara had accepted whatever dress the mother had given her and had stopped annoying the baby. There had been no further complaints of earache. The patient reported that she was "all right."

Q: Why have you been so nice?
A: 'Cause I want to.
Q: What did you learn here?
A: If I didn't do what she [the mother] told me, she'd go to heaven, and I wouldn't have any mother. And a nurse would have to do all the work.
Q: So?
A: I'll be good. I don't want that.

The child who becomes fearful has a particular life situation to which he is reacting. It is not sufficient to state that the patient is an emotionally unstable child who has been subjected to a frightening situation. In each individual case there are two important questions that must be answered: First, why has this specific fear state been elaborated out of a number of available fear patterns to which the child has been exposed at home, in the neighborhood, and in the movies? Second, does this fear state help the child out of a difficult life situation? The function of the fear, which is accepted and strongly reacted to, must be considered in every case.

Rita was a ten-year-old child of low normal intelligence, the daughter of a dull, nagging mother who was constantly complaining of diffused aches and pains. The child was a whiny, thin little girl who ate poorly, was afraid of the dark, and had many somatic complaints as well as a marked fear of being kidnaped. The mother said, "I always tell her not to go with strangers and to holler for help if a man would attack her." Here, apparently, was the source of the fear of being attacked and kidnaped. But why had this particular pattern of fear been accepted by this timid, apprehensive child?

The answer lies in the life situation of the child. Rita was the elder of two children. Her younger sister, Gloria, aged eight, was the father's favorite child. She was called "smarter" and "prettier" than the patient. Rita was obviously at a disadvantage in this family setting. How could these facts explain why the fear of kidnaping played such a significant rôle in her life? Rita furnished the necessary connecting links in an experimental play setting. She had placed two dolls, each in its own toy bed:

Q: These babies are . . . . ?
A: Asleep.

Q: Let's see what happens.

A: The little one woke up. She sat on the floor. The other one woke up. They started to call their mother.

Q: Why?

A: She [the older one] wanted something to eat.

Q: Why?

A: She wanted the little one to go downstairs.

Q: Why?

A: Somebody might come up and grab her [the younger sister].

Q: Why?

A: Because her mother all the time tells her stories, and they believe it—about a baby who was sleeping in bed and a kidnaper came in and kidnaped her.

Q: Whom?

A: The baby. They started to believe it and thought it was true.

Q: Why?

A: Because she [the older girl] thought that her sister was going to be kidnaped. . . .

Q: How does she feel?

A: Not so good. She thinks the kidnaper will get her, and she makes out she takes up for the youngest one if the kidnapers would kidnap her [the younger sister].

Q: Then she'd feel . . . ?

A: Better.

Q: Why will she feel better?

A: She isn't so smart as the other.

Q: And . . . ?

A: She wants to stay home and play herself.

Q: Why?

A: She'd get more—she'd get all the clothes. . . .

Q: Now what does she understand?

A: About the kidnaping. When somebody tries to kidnap her sister, she won't let them. . . .

Q: Before?

A: She'd feel glad. Now she don't. Now she remembers she ought to feel bad about it.

Q: Whose idea was it?

A: The oldest one. She won't be frightened because she understands a little.

Q: What?

A: She said, How would she feel if she got kidnaped? She began to think, and then she said she wouldn't like it, to have her sister kidnaped. . . .

Q: Whose idea is it, the kidnaping?

A: The oldest one's.

Q: What does that explain to *you?*

A: That I won't be afraid of the kidnapers.

During the third session, the patient played out what happened when the doctor examined her mother and her younger sister. They were found to be free from pains and aches. She was told: "Now the oldest girl is on the table."

A: She says everything hurts her—her hands, her head.

Q: What else?

A: Her stomach, her back—that's all. . . .

Q: Why?

A: Her sister hits her in the head.

Q: What other reasons?

A: She all of the time thinks of her mother. The mother likes her, not the young one.

Q: Why does that make her head hurt?

A: Her father likes the young one and don't like the old one.

Q: What has that to do with her head?

A: She all the time thinks about her father.

Q: Which way?

A: That her father likes the sister.

Q: Why does she have the pains?

A: She wants the pains.

Q: Why does she want the pains?

A: To hurt her. When the pains hurt her, her mother takes care of her better. The father takes care of the youngest. . . .

Q: What did *you* learn about wanting the pains?

A: That the mother would like her better.

Q: Does that help *you* understand the pains?

A: Yes. . . .

Q: Why?

A: Because that if she would get the pains, her mother would like her more, and she'd get more presents.

The fifth play session revealed the patient's attitude to the younger sister, who was the father's favorite child.

The patient began by placing two babies in a crib and setting up a girl doll to rock them to sleep. Spontaneously she announced: "She is waiting for her sister and father and mother. She is the youngest sister. . . . The older sister comes in. . . ."

Q: What does she think?

A: She said she was thinking about her sister.

Q: What was she thinking about?

A: She might go out and walk and walk and not look at the street and get lost. When she crosses the street, she might get run over. . . .

Q: And she wants . . . . ?

A: Her father to take care of her.

Q: Like . . . . ?

A: Her father took care of the youngest sister.

Q: She wants . . . . ?

A: The father.

Q: Why couldn't she have the father before?

A: Her sister had him.

Q: Therefore, she wants her sister . . . . ?

A: To die.

Q: What about the headaches?

A: She was thinking of her sister. . . .
Q: Can that help her headaches?
A: Yes, because she'll know that the headaches . . . .
Q: Came from . . . . ?
A: Thinking of her sister.

In this manner Rita was able to discuss her jealousy reactions and was desensitized to her fear of kidnapers. After seven contacts (between March 10, 1933, and April 25, 1933) she began to play less apprehensively, the body complaints disappeared, and for the first time she was at ease with strangers, was able to sleep without a light, and no longer was afraid of being kidnaped. Six months later a visit to the house by the social worker [1] revealed that Rita was well and had no complaints. At this time it was reported: "She is not afraid of anything any more."

The interrelationships of jealousy, fear, and hate and their effects upon the behavior of the child are illustrated by the following play material. The case also illustrates how the play interview can be used to supplement the direct psychiatric interview with older children.

Eva, sixteen years old, was an aggressive, emotionally unstable girl who had run away from several foster homes and was known to drink, to smoke excessively, and to have had sex relations.

As a child, Eva had a history of prolonged temper tantrums, petty stealing from her mother, and truancy, and had finally been expelled from school. She had failed twice in the seventh grade, despite the fact that she had achieved average intelligence scores on two psychometric tests.

There were an older brother and a younger sister in this home who had made fairly good adjustments. The father was a self-assertive, industrious working man, a stern disciplinarian. The mother was an oversolicitous, emotionally unstable woman of limited intelligence.

A lead as to some of the personal sources of these emotional outbursts was obtained when Eva became fearful that she was ill with meningitis. A girl friend had recently died of this disease, and the patient had dreamed of her death. Eva had awakened frightened, and had felt as if she were

[1] The author is indebted to Miss Barbara J. Ashenden for her assistance.

suffering from the same illness. Not infrequently she would tap her knee and feel her neck to see if they were becoming stiff.

Eva went on to say that she was afraid to see a dead person. She said, "It even makes me sick to hear about it." When she was eight years old, Eva had been told that some one had died in the house in which they were living. She had become frightened and now stated, "I hated to stay in the house. I was afraid they might kill me or strangle me." It is of significance that Eva always imagined that it was a woman who lay in the coffin whenever she heard or dreamed of a dead person. This was the case even if she had been told that it was a man who had died.

There had been similar episodes of terror, during which Eva had been unable to sleep at home, whenever any member of the family had died. In an attempt to determine what attitudes were associated with these fears, the patient was asked to act out these imaginations by means of dolls. A girl doll was placed beside an adult female doll, who was supposed to represent a dead body.

Q: What does she [the girl doll] think?

A: Some one might strangle her. She is afraid and thinks she has done something. She's afraid of death and afraid of being attacked. When I saw the movie, *San Francisco*, I became afraid of earthquakes. I'm afraid I'll be killed. She acts as if she killed the dead person—as if she murdered the corpse.

Two girl dolls were placed side by side, and the patient continued: "The big girl is jealous of this little girl because she is the baby. The mother was more affectionate for the baby. She [the older girl] develops a jealousy, and then a hate of her sister."

Q: How does she show this hate?

A: Fighting with the sister, taking things away.

Q: And . . . . ?

A: She hit her at night. Once I took a pan of boiling water and threw it on her leg. She acted like she don't like me and that made me hate her more. I tried to kill her. It used to burn me up.

Q: Who is the corpse?

A: It's my sister. This big girl thinks her sister will pay her back for the way she treated her. She [the older girl] wished the sister were dead. I wished that she would go away and never come back, and in the dream she comes back to repay me.

In this way Eva was able to accept the responsibility for the hate and jealousy that led to her fears of death and meningitis, and went on to discuss her desire to be a boy. She related how she had wanted to play football and to climb fences. She thought of other girls as "sissies." Eva said, "If I could only be a boy and play rough games and go hiking. My father and brother were like pals."

The personality changes that occur when a parent decides to alter the natural growth tendencies of a child is illustrated in the next and last in our series of case histories. What takes place when a mother makes up her mind that she wants a girl, when the child is a boy? What can the child do about a behavior pattern that has been forced upon him? The following material demonstrates what the child is thinking, while he apparently is accepting the desires of such a determined mother.

Charles, aged ten years, four months, was experiencing a serious behavior disorder when he was brought to the psychiatric clinic of the Harriet Lane Home in February, 1933. The mother gave the reasons for bringing him as follows:

> "It's that scary disposition at night; in fact [even] during the day he is afraid to go from one room to the other or to go to the cellar. He is afraid there is something wrong; otherwise he wouldn't act this way. His favorite is playing with girls; he takes after his daddy that way. He bites his fingernails. I have painted them with iodine and mercurochrome. I told him if he swallowed the nails, they would lodge in his lungs, and he would have to be operated on. He still does it. When the doorbell rings, he runs back to where the crowd [family] is. I have taken him by the hand and showed him there was nothing to be afraid of, but it don't help. Street cars make him deathly sick ever since he has been in the world. I first noticed it at several months of age."

The present condition had begun insidiously during the preceding summer. During August, 1932, seven months before the first interview, Charles had become apprehensive and fearful while spending a vacation on an aunt's farm. He had failed in school for the first time (Grade 4 B) and had anticipated being sent back to the class of his former teacher. He had greatly disliked and feared this woman because of her "hollering" at the class and her rigid disciplinary methods.

His apprehensiveness had increased until by December,

1932, he had become fearful every time the doorbell rang. He began to postpone going down into the cellar where the lavatory was until he not infrequently wet himself. He acted as if frightened when he had to pass from one room to another. He cried out and was restless during the night. Nevertheless, he had attended school regularly all during this period.

The mother had been disappointed when she had learned that she had given birth to another boy baby. She had wanted a girl baby during her first pregnancy and was doubly anxious for a girl before Charles was born. She immediately turned all her efforts to raising Charles as if he were a girl. She protected him against the "rough" boys of the neighborhood and kept him dressed as a girl until he was three. Except for an occasional girl, Charles had no companions until he was sent to school.

He was called "sissy" by the boys, with whom he could never get along, but was a favorite with the girls. He reached the fourth grade before he failed. Achievement tests revealed that he was below grade in both reading and arithmetic. He had been given a group intelligence test and had scored a rating of dull-normal intelligence (I.Q. 91).

The teachers noted that he was afraid to play with boys because he might soil or tear his clothes. One teacher wrote: "He is tolerated by the girls and hated by the boys. He antagonizes the other children by tattling on them. He acts like a girl, even talks like a girl; he uses expressions like, 'Oh, my gracious!' "

Charles was so particular about his appearance that he would never wear his old clothes. He never fought when he possibly could avoid it. He washed his hands many times a day. He recently had put nail polish on his fingers. He had been carsick since early childhood. He had been fearful of being kidnaped for some time before he came to the clinic. During the time of the Lindbergh kidnaping (1931), he had spoken of his fear of being kidnaped.

Charles was an affectionate child who liked to kiss and be kissed by both parents. For a long time he had demanded the first kiss after his father shaved in the morning, saying, "Don't let mother have it." He also wanted the last kiss before his father left home in the morning.

There was one sibling, four years older than the patient. He was described as a "regular boy" and very much interested in athletics. He teased the patient, calling him "sissy." The mother had tried her best to make him also act like a girl, and, at the age of six, he had had to outwit her (with the help of his father) in order to have his hair cut short.

The mother was a tall, energetic, asthenic woman. She was fearful and constantly worried that her husband might be injured at his work, which was inspecting gas tanks. When he was a few minutes late, she became upset. She was subject to car sickness and was also fearful of high places. The father had an easygoing disposition. He occasionally still had night terrors and recalled that as a boy he had liked to play with girls. There was no other evidence of either major or minor behavior disturbances in the family history.

The physical condition of the patient was negative except that he was slightly overweight, with a moderate degree of lumbar lordosis and chronically diseased tonsils with some cryptic exudate.

The mental status of Charles, when first observed, was as follows: He was a friendly, coöperative child, who entered the room with a cheery greeting. His mannerisms were girlish. He sucked his fingers, and his nails were closely bitten. Charles spoke with a slight lisp and was a mouth-breather. He readily discussed his "fears and nervousness." He spoke of running home "all scared" in order to see what might have happened to his mother, who he was afraid had been injured in an automobile accident or by falling from a window. At times he thought that his father might have been hurt in an accident.

He said that his hardest school subject was arithmetic and he read with many errors. "Civil" was read as "carnival," and "nerve" as "never."

Charles stated that he first had played with boys three months before the interview, but as they had built a bonfire and talked "dirty," he had left them and had never returned to play with them. He preferred the company of girls because they were not so "rough."

The patient was given his first opportunity to express his own ideas and feelings in a series of play interviews. It was

decided to begin with a study of the reasons for his nausea and vomiting on street cars.

A toy car with two chairs was set up to represent a street car, and a boy doll, a lady doll, and a motorman doll were placed in the car.

Q: Where are you going?

A: Uptown. (*Calling out*) Baltimore Street! Anybody want to get off? Lexington Street! Johns Hopkins Hospital. . . . The lady says, "I want to meet my husband." While they are going, the motorman drops dead. The seats go over (*throwing over the seats and dolls*).

Q: How did it happen?

A: Somebody shot him, and the bullet went through the car and killed the lady.

Q: How does the little boy feel?

A: He's happy. It wasn't him this time.

Q: What does the little boy expect to happen?

A: He expects an accident. He's afraid he might get hurt—he'll get in an accident. He feels unpleasant. He's afraid it might happen to him. He don't want to ride on cars. He thinks he is going to be hurt. The car might turn over. He might go out in an auto—the auto might turn over.

Q: Afterward?

A: He feels good after he gets off.

Q: He feels like, just like . . . . ?

A: Like I do. I feels skeared sometimes. I felt skeared Saturday coming up here. I saw a horse and buggy almost hit the car. It might have killed my father and I—I was sick. . . .

Q: What might happen?

A: I am scared of my mother and father, because they might get hurt.

Q: What are you afraid of most?

A: My father. He's always climbing on the tank three hundred feet high.

Q: Why does the little boy vomit?

A: He gets sick, same as I do. . . .

Q: Now?

A: I know I worry about my mother and father.

Q: Before?

A: I used to think I ate something.

During the next three sessions Charles played as if he were a girl. He discussed women's clothes, dancing, and frequently spoke of not liking boys.

The notes taken in the sixth play interview (February 25, 1933) reveal the attitude of the patient toward boys:

Q: Whom does the little boy like to play with?

A: Girls.

Q: Why?

A: The boys are too rough.

Q: How?

A: Smoking, cussing, getting dirty, racing, running, playing ball.

Q: What would he like to do?

A: Take walks [and] play with girls; skip with them; tell stories.

Q: Why?

A: He thinks it's nice. The boys are too bad. . . .

Q: How does he play with the girls?

A: He tells riddles. "You!" (*speaking to doll*). "What goes upstairs on eight legs and comes down on four?"

"A cow."

"No. You!"

"Two cats go up and one comes down."

Q: How does he play with the boys?

A: (*Putting a small boy doll in front of a group of boy dolls*) "Now we got you, haven't we?"

"Now, what have I done?"

"You know. You threw a brick at me."

He knows he didn't do it. *She* pulls this boy's hair. I mean *he* begins to fight. He has his feet around her. She has her —— (*He is using "he" and "she" interchangeably.*) I don't like it so well. It's rough.

Q: Why rough?

A: He's tackling her; he is tearing his pants; he's mad. This little boy is beating this big boy. She's finished with; he's stamping on her . . .

Q: Who is she?

A: It's a lie. (*He makes the boy doll stamp on the female doll's head.*) He scraps her around the street. He's trying to kill her. (*He repeatedly bangs the doll's head on the floor. He becomes very noisy. He "wipes" the table with the female doll.*)

After Charles had played out his fears of boys, as reproduced in the notes of the sixth session, the mother reported in the seventh session (March 2, 1933): "He is improving in going through the house and on staying home alone. He didn't look like my boy, his hands were so dirty last night. Before that he never had dirty hands. He really looked out of place."

At the same session the patient reported as follows: "Let me tell you something. My mother went out and I stayed home alone, all by myself."

Q: Previously?

A: I'd be scared. I'd think I'd hear somebody at the front door, that somebody would come in and take something—money or something. I haven't been as scared as I was. Yesterday I did my home work all alone in the house.

The patient also reported that he had begun to play with a boy and had enjoyed this contact for the first time. He

added: "The boys play better games than girls. Two months ago I played with girls. I speak to girls [now], but I don't play with them."

Nevertheless, the need to play out the killing, beating, and choking of a female doll was present. The seventh and eighth sessions brought these demonstrations to a climax. There was a noticeable decline after this time in the boy's effeminate manner of expression and his interest in feminine topics of conversation.

Charles was getting to the point where he could identify the female doll, who had been mangled or killed by her falls and accidents, as his mother. By the tenth hour (March 11, 1933), the car sickness had disappeared to the extent that the patient was able to come to the clinic, on the cars, unaccompanied. The next three sessions still contained narratives in which women were being killed, slapped, or banged around.

The fourteenth session (March 30, 1933) was introduced by the mother with the statement: "He goes from room to room without any fear. He goes down in the cellar. He comes home pretty soiled. That's something unusual. He's playing more with boys. He didn't play with boys at all before."

It might be of interest at this point to inquire about the mother's attitude. How did she account for these changes? How much did she know concerning what was going on in the playroom? She was asked: "How do you explain these changes in his behavior?"

A: I don't know. We did everything, but it was of no use.
Q: Do you think he just outgrew it?
A: No. It must be something you people did here.
Q: Why?
A: Because he couldn't outgrow it in such a little time. He is just as loving as ever. I get my kisses just the same. I am very well pleased. He comes over in the street cars. He doesn't come home and say he is sick over that.

During the sixteenth session (April 6, 1933), Charles related the following story, in which was described his emancipation from the feminine attitudes forced upon him by his mother and the sources of his fear of being kidnaped. He selected a toy house and a boy doll and spontaneously began: "There

was a little boy. He came to a house. He opened both doors wide. If he saw anything, he'd run. He walks in this room; he don't see nothing . . . He goes in this room. He sees a baby girl. He pulled the baby girl out and threw her out of the window."

Q: Why?

A: He knew that his mother never had a baby girl. . . . The little boy goes into another room, the bedroom, where he found a little baby boy. He [the baby] was calling, "Mama!" He threw the baby out of the window. He knew that his mother had one boy. He was the only child. He looked out of the window and saw a lot of colored men, and the colored man ran home with the baby.

Q: That's a nice story.

A: That ain't all yet. He shuts both doors. He hears something fall, the door opens. Do you know who it was? Guess who!

Q: You tell me.

A: It was his father in his sleep. His father was down the cellar, and the father was in his sleep. And the boy thought it was a man.

Q: Who?

A: A colored man, and it was his father . . .

Q: Who was the little girl? She is just like . . . . .?

A: I don't know.

Q: And the little boy is like . . . . ?

A: He wasn't one foot tall. He was a baby boy. He was like me.

Q: And the baby girl?

A: The baby girl is like me. Don't put it down. Don't write it down! (*He gets up.*)

Q: He threw the other boy out of the window so that . . . . ?

A: He was the only child.

Q: Who was the one he threw out of the window?

A: The girl. His spirit! Don't write that down.

Q: What is "spirit"?

A: It's his shadow, his spirit. He knew that his mother never had another boy.

Q: And that little boy . . . . ?

A: He was his cousin Hugo, his imaginary cousin.

Q: Who was the little boy?

A: He was his brother.

Q: And he [the brother] went out of the window . . . . ?

A: So he could be the only boy.

It was reported at this time that Charles of his own accord had requested a separate bedroom. Before that he had slept with his brother. He went to bed alone and fell asleep without a light. He continued his play with boys and reported the "fun" he was having.

His improvement had been maintained when he was seen eight months later (nineteenth session, January 12, 1934).

He spoke of enjoying "gym, soccer, and indoor baseball." He had played touch football.

Q: Do they play rough?
A: Not so rough. You block them in to keep from touching the ball.
Q: Do they knock you down?
A: Sure. You just get up and play over again.

Charles had passed and was doing fairly well in the sixth grade. He had repeated the fifth grade during the previous year. He had lost all of his girlish mannerisms, and he no longer confused "he" with "she," as he had formerly done. His stories were about "cowboys" and contained no references to dresses or ribbons as in former interviews. The patient refused to play with the dolls during this (the nineteenth) session, saying, "I don't like to play no more. They [the dolls] are girls' things."

The twentieth session took place on March 5, 1935. There had been an interval of two years between the first session and this. The patient had passed the sixth grade. He was boyish in all of his mannerisms. Charles announced that he remained at home "all by himself." His mother was afraid to stay at home alone. He had come unaccompanied to the clinic on a street car. His mother could not come as she was still subject to car sickness.

Charles was able to recall the complaints which had brought him to the clinic three years ago: "I used to get sick, but I don't any more."

Q: Why?
A: You made me well so I wouldn't be scared any more. I learned that there was nothing to be afraid of. Before, I used to think my father would fall off a tank and used to be worried about my mother.
Q: What did you think of?
A: I used to think about my mother, of an accident—that if I was in an accident I might get killed and [also] the driver and my mother. I just wouldn't see my mother any more. It would be imagination. I used to think that my mother would fall out the window while washing the window.
Q: When did you have those thoughts?
A: When riding on the street car.
Q: What else?
A: Some automobile might bump into the street car. It would turn over and kill me and my mother.
Q: What was going on in your imaginings?
A: I was trying to be a girl. I used to let my imagination run away with me. I used to imagine my mother would die. She was trying to

make a girl out of me. I didn't want to be a girl; I wanted to be a boy. I thought about my mother falling. It was only nonsense.

Q: Not exactly. That's the way you did what?

A: Turned into a boy. She used to treat me like a girl. I dropped her out of the window. She got hurt. She was killed and buried.

Q: Why?

A: So I could be a boy. I had to kill her.

Q: Where?

A: I dropped her out of the window and on the street car.

Q: What happened?

A: An accident.

Q: And all that . . . . ?

A: That was to get rid of her.

Q: So . . . . ?

A: I could be a boy.

Charles was seen last (twenty-first session), after another interval of two years, on September 25, 1937, four years and seven months after his first visit to the clinic. He reported that there were no complaints of car sickness or fears. He was in the eighth grade at the age of fourteen years, eleven months. He said that he enjoyed playing ball with the boys and was getting along well with them. He had grown rapidly during the interval and was five feet, eleven inches tall and weighed one hundred and fifty-two pounds. At this time he was asked: "Do you remember what was the matter when I first saw you?"

A: I was scared of my mother, that something would happen to my mother. Now I have my own door key. I come in by myself, and I don't worry about my mother.

Q: Do you remember why you were upset?

A: I was always scared she'd fall and hurt herself.

Q: Do you recall why?

A: I don't remember.

Q: Your mother was anxious for a . . . . ?

A: Girl.

Q: How did you feel about it?

A: I used to play with the girls a lot. I wouldn't play with the boys.

Q: Why?

A: I don't know.

This material illustrates the variety of factors that may be involved in the production of a fear state in a ten-year-old boy. There was the physical finding of infected tonsils and a history of school difficulties, which included a degree of reading disability, dull-normal intelligence, and a domineering teacher. There was an emotionally unstable mother, who

had determined to make her son think and act like a girl, and there was the personality make-up of a boy who had been able to accept and to adapt himself to this type of behavior until the onset of the present illness. In this psychobiological setting the patient developed a state of insecurity in which general apprehensiveness appeared; then fear of being alone and of being kidnaped and imaginations that his mother might be injured at home and on street cars and that his father might be hurt in an accident while at work or while riding in a vehicle.

The play interviews provided an opportunity for the child to express himself. He utilized them by repeatedly punishing or killing his mother and by producing a dramatic account in which he disposed of "the baby girl that his mother never had" and of his older and more masculine brother. During the period of observation he became aware of and accepted the responsibility for the rôle he had played in his illness and began to behave like an average boy, free of his fears and secure in his family relationships.

SUMMARY

The clinical and biographical studies that have been presented emphasize the fact that there can be no royal road in the collection of the data that help to explain child behavior. No one theory can account for all the factors in any one case. There is the factor of original endowment, as well as the developmental, physical, and situation-determined factors, to be evaluated. The attitudes of the parents, of the school-teacher, of the child's associates at home and in the neighborhood must be studied as they affect the child in his daily life.

In the difficult, painstaking labor of collecting all of these significant items, there is one important consideration that too often is forgotten—namely, that the child himself has something to contribute. The child, like the adult, has a biography, which includes important past experiences and a present life situation. In addition to the need of working with the family situation, the school, and the community, there are the emotions of the child to be taken into account.

The child has a need to express his dissatisfactions, his

fears, and his hopes in his own natural fashion through the medium of play. In this way he can begin to understand what he has contributed to the total situation, and thus to accept his share of the responsibility for what is going on.

It is hoped that these clinical facts, derived from the life situations and imaginings of children, will aid the worker in the field of child behavior to understand the child as he really is—an individual with his own feelings, thoughts, and interests.

CASE-WORK IN AN AUTHORITARIAN SETTING

JOHN SLAWSON, PH.D.
Executive Director, Jewish Board of Guardians, New York City

PERHAPS it would be better in our discussion to interpret the term, "authoritarian setting," as signifying the "official situation" in relation to case-work, for otherwise the term seems to imply an attitude opposed to individualization which is by no means necessarily operative in official case-work—certainly not where the standards of performance are of a high order. What we probably mean to include in the category, "authoritarian setting," are case-work activities in the courts, on probation, on parole, in the reformatory, in the prison, and in other official agencies whose paramount obligation is the protection of society against the offender or against those whose potentialities are in the direction of conduct harmful to society.

This obligation of protection, it is argued, is much less potent a factor in the private case-work agency than in the official setting, thus making it more possible for the former than for the latter to employ procedures and techniques in the interest of the recovery of the client from the undesirable symptoms that constitute his maladjustment. It is felt that, in the light of this obligation, and for related reasons, the official agency can afford to a lesser degree than the organization under private auspices to employ treatment procedures of a voluntary nature, because the official case-worker is obliged to insist that the client conform to socially acceptable behavior, and if necessary to force him into this social conformity. If case-work in general had continued to be an intellectualized, fact-finding, or purely manipulative type of activity, perhaps the differences between the opportunities for treatment in the official and in the unofficial case-work fields would have appeared to be less striking. It is the psychotherapeutic form of case-work, dependent upon the medium of the relationship between worker and client and so largely

influenced by psychoanalytic thinking, that has caused many to feel so keenly the restrictions of what is referred to as the authoritarian setting in the process of treatment.

It is what Roscoe Pound terms "the tendency to perfunctory routine" in the official setting that is in such sharp contrast to the basic requirements of treatment procedures that are largely dependent upon the worker-client relationship. As is well known, this approach calls for variability and informality rather than perfunctoriness or formalism—an informality that is made necessary by the very nature of personality and the emotional needs of the client. Cumbersome machinery, heavily laden with routines of regular reporting, prescribed visitations, and general inflexibility—either necessitated by heavy case loads or due to mechanical attitudes—are, of course, obstacles to the operation of psychological techniques. It is further contended by some that the very nature of the official setting, which does not meet the requirement that the acceptance of aid by the client shall be voluntary, makes difficult, if it does not altogther prevent, the formation of that confidential relationship which is the basis of treatment.

While these generalizations are true for a goodly number of those official agencies whose case-work standards are low and whose professional leadership is inadequate, they must be seriously qualified in a discussion of the current work and possibilities of the official agency with high standards of performance. Official agencies can, and a number of them do, show wisdom in the utilization of case-work tools in the official setting, and not only minimize greatly the handicaps attributed to official case-work, but actually exploit this setting in the interest of effective treatment. Now what are some of these very important qualifications?

It is fairly well established that the worker-client relationship, so important to treatment regardless of setting, is dependent upon two main factors—the suffering experienced and the need felt by the client, on the one hand, and the degree of acceptance of the client by the worker on the other hand. Whether it is a private or an official agency, if suffering is not experienced and need is not felt by the client, a meaningful relationship is difficult, if not impossible. Take, for example,

the case of the psychopathic type of individual who either finds it hard or is unable to relate himself to others. The treatment of such individuals calls for other methods than the now commonly accepted expression-and-interpretation approach operating through the worker-client relationship. The official agency is blessed to a much greater extent than the private case-work agency with the psychopathic type of individual—the type of individual who is not necessarily diagnosed as psychotic, but who does not relate himself to others and who has very little feeling of guilt, who appears to be suffering in varying degrees from what may be termed "deadening of emotional content." The larger proportion of this type of client in the official agency is due to the fact that they are found to a greater extent among offenders than among clients of private case-work agencies. For this group I am not certain whether, if wisely employed, the so-called authoritarian setting may not be the correct setting. Evidence for this view is to be found in the frequency with which private agencies, at certain stages in their contact with clients, will turn to this or that official agency for the initiation of changes in environment and other forms of treatment which they have been unable to effect through the purely voluntary relationship. All of us know that when a change of home becomes necessary for a child and neither the child nor the mother can be made to see the wisdom of such change or to feel the need for it, the official agency is employed, and wisely so, to initiate this change. We know of many instances in which a private agency, employing psychological case-work methods and social treatment with a person of psychopathic pattern, has discovered that it can make progress only after the client has found his way to court and after one adjournment after another has been obtained. The necessary environmental change having been made through the instrumentality of pressure by the court, efforts at treatment become possible.

The other main factor in treatment—the matter of acceptance on the part of the worker of the client as he is, as a person who needs help and treatment rather than one who is condemned because of the offense he has committed—is not often as easy to provide in the official as it is in the unofficial agency. The law-enforcement atmosphere may affect the

attitude of the official case-worker unless he is well trained and, more than that, possesses the kind of personality that can accept so naturally and so sincerely the client whose conduct is socially harmful that the client can feel free to establish a confidential relationship, the basis of treatment. It is in the personality make-up and the professional equipment of the probation officer, parole officer, or institutional case-worker that the key lies for the opening of the door to a therapeutic relationship through which treatment may go on. It is true, of course, that the official case-worker is at first not wanted—he is superimposed by the arm of the law upon the client. But the initial rejection in no way implies that the afflicted client (offender in this case) does not yearn for a relationship with an understanding human being, and he can form this relationship with the very worker whom he at first rejected, provided the worker's attitude is therapeutic and not condemnatory nor authoritative because of his own need to exercise authority rather than because of the client's need, in the light of a treatment plan.

We must not forget that the cases referred to private case-work agencies are not so voluntary after all. Perhaps the only truly voluntary contact is that between patient and private practitioner. In the private case-work agency many of the cases are referred from schools and other social agencies, or are brought by parents or relatives, and the client who does come of his own accord comes for something entirely different, frequently material aid, from what he ultimately receives in the treatment process, often without ever obtaining what he originally came for.

We should not minimize the limitations of the so-called authoritarian setting, but there are many qualifications of these limitations and, as we have said, in some instances this setting may be constructive. With many types of client the limitations of the official situation in relation to case-work treatment can actually be faced, can be discussed with them. With some regard, of course, to the nature of the client's personality pattern, he can be told that while it is true that as his probation or parole officer, the worker may have to report some of his transgressions, yet if he does not discuss these with the worker and deal with the difficulties, he

will not improve. In certain instances, such frank facing of the situation works. It takes experience to know when to use this approach, but with some individuals it is far better to do this than to simulate a purely confidential relationship which the client, particularly if he be intelligent, knows cannot wholly exist.

If the relationship is strong enough, if the psychological pain felt by the client is deep enough, the confidential content will come through in spite of the official setting and the fear of disclosure. There are workers in the official field as well as in the private field who need to dominate, and because of this need, they exercise a kind of authoritarian attitude that arouses a hostility in the client that not only does not contribute to a process of socialization, but actually increases his rebellion against authority and may make him more criminalistically inclined. In such a situation, outwitting the parole or probation officer may actually become a pleasure.

This does not mean that the relationship between worker and client must always be "sweet." It should not be. As a matter of fact, it is frequently necessary to activate the repressed hostility and aggression in the client, but this can be done constructively only after an inner assurance of the affection, sympathy, and understanding of the worker has been built up in the client. At that point, even a planned authoritative approach can be instituted, but it must fit the client's need and not be merely an expression of the case-worker's own aggressions. This approach is frequently used also in the private agency that employs the best and most recent forms of psychotherapeutic techniques, but is not addicted to any single philosophy of treatment regardless of the consequence to the client. In work with delinquents, to a much greater extent than in other types of case-work, the capacity to instill a desire for help on the part of the client should be great. More so than other case-workers, probation and parole workers need to develop this skill.

One of the major difficulties in the authoritarian, or official, setting is either the inadequacy or the total absence of diagnostic thinking, because of pressure of heavy case loads, lack of training on the part of the worker, or the absence of psychiatric facilities of a dynamic nature. As a matter of fact,

in many instances mere supervision of the client is confused with case-work treatment, and when case-work *is* attempted, the type of personality structure with which the worker is dealing is not made clear nor are the limitations of the client's adjustability determined. Frequently the sole concern is with the goal of social conformance. Determination of the type of personality structure, other than the diagnosis of definite psychopathological states, is fundamental to the plan of treatment. Shall it be of a supportive nature, making available to the client emotional and other help until he is strong enough to face reality? Shall there be a basic working through of the client's problems? Shall there be an emphasis on an effort to help him free himself from the social pathology under which he is laboring? Shall authority be exercised for the immature, for the individual who has not as yet grown up psychologically? Or shall there be a combination of all these techniques at different stages of the treatment process, or perhaps a completely different combination of approaches for those who do not form effective relationships?

Dr. David Levy, speaking of the emotional pathology caused by rejection from infancy and the affect hunger that flows from this form of rejection, queries, in a recent paper, as follows: "Is it possible that there results a deficiency disease of the emotional life, comparable to a deficiency of vital nutritional elements within the developing organism?" I am sure that many probation and parole officers have recognized such states in their clients. There will, therefore, be cases that are inoperable from the point of view of psychotherapeutic case-work, and for whom some form of environmental change seems to be the one thing that can be done in the present stage of our knowledge.

Classification for treatment accompanies diagnostic thinking. We have learned to classify in our institutions for purposes of vocational training and for institutional assignments, but we have not fully considered classification for treatment, either in the institution or in probation or parole work. This kind of classification—which should be of a dynamic and not a static nature and which should continue to change and parallel treatment and not be once made and never changed—would make possible the selection of a certain number of individuals

from a worker's case load for the purpose of more intensive case-work treatment. The remaining group might just be supervised, especially if the case loads are too high or if the material does not seem to lend itself to treatment. High case loads will, of course, make it impossible to introduce effective case-work treatment measures in the official field. As long as high case loads continue, indiscriminate, undiagnosed, unplanned, and ineffectual case-work efforts will continue, be it in the official or in the private field.

Furthermore, there is a woeful lack of sufficient professional supervisory facilities in most official case-work set-ups, resulting in low standards of performance, stultification of professional growth, and ineffectual routinization. Case-workers, official and unofficial, must always have the opportunity of continued thinking, guidance, and consultation. No private agency that can claim performance on even a minimum-standard level works without adequate supervisory facilities. Psychiatric consultation, if limited merely to the determination of pathological categories, psychotic or not psychotic, is of little help to one attempting dynamic treatment of the offender. Over 80 per cent of offenders do not belong to these categories, as was very recently determined by Drs. Walter Bromberg and Charles B. Thompson, working in the Court of General Sessions, on the basis of their completion of the examination of 10,000 offenders during the four-year period, 1932–1935. It is in dealing with this 80 per cent whose deviations from normal behavior are due not to pathology, but to behavior disorders, that psychiatric advice is so much needed by the case-worker. Unfortunately, in the official case-work field psychiatrists equipped for such service are few.

It becomes evident, therefore, upon analysis of the possibilities within the so-called authoritarian setting and the limitations incident to factors other than those inherent in the official setting, as such, that we must direct our efforts to elimination of the difficulties encountered within the official field and not dwell so much upon the limitations inherent in the setting itself. Personnel well-equipped in personality make-up and training, adequate case loads, diagnostic thinking, classification procedures and treatment selectivity, supervisory facilities, professional leadership, psychiatric and

other specialized consultation opportunities—these and others of a similar nature are the factors lack of which limits our effectiveness in the so-called authoritarian setting, much more and to a far greater extent than the technical and philosophical implications inherent in the official setting itself.

Studies of certain prison case-work set-ups have revealed that the keeping of records is being confused with case-work. There are masses of records in prisons, but few "inner life" histories of prisoners. The records consist primarily of external facts, most of which have very little, if any, bearing upon treatment plans, which are rarely instituted. The clinical and case-work set-ups in many of the prisons that have been studied are so inextricably interwoven with the official administration that there is confusion in the mind of the inmate as to who is a house officer and who is a case-worker. The mixing of case-work and disciplinary functions is fatal. Such admixture does not meet the minimum requirements of case-work treatment. Outside of such groupings as the psychotics, the epileptics, the feebleminded, and other crude categories, there is no classification for treatment purposes in the prisons. We have seriously attacked, especially in New York State, the educational and vocational problem in the prisons, and I think we have made some encouraging progress. We have not even begun really to be serious about the introduction of treatment measures for the personality illnesses of our prison clientele.

The feasibility of case-work treatment has been demonstrated in some of our institutions for juvenile delinquents, but with few exceptions the very same negating factors that we find in the prisons are in operation here also, such as large case loads, lack of professional supervision, poor treatment classification, and confusion between case-work and disciplinary functions. In an institution for delinquent boys, in which the case load is approximately 30 or less per worker and where the psychiatric staff is adequate in number and quality for the population, the possibilities of case-work treatment in the institutional program have become apparent. The case-worker is not only the liaison person between the various factors in the environmental situation within the institution—the cottage parent, the school, the recreational and social set-

ups—as well as being concerned with the home situation during the stay of the child in the institution, but, under adequate professional supervision, he engages in actual treatment, frequently in consultation with the psychiatrist. And here there is a very definite demonstration of the possibility of overcoming the officialdom connected with the entry of the boy into the institution through the medium of the children's court. By means of a creative and informalized program of activities within the institution itself, and because of the quality and skills of the case-workers and the clinical staff, this obstacle is being overcome. The relationship here between the case-worker and the boy, in spite of the fact that the boy was sent there by the court, is not markedly different from the relationship between the case-worker and the boy in a child-guidance clinic in the city. The atmosphere of the institution, plus the skill and personality of the case-worker, have overcome to a marked degree the repressed hostilities and suspicious attitude that might have been expected from a boy sent to an institution by the court and that would ordinarily tend to block the formation of a treatment relationship. The atmosphere and the personnel within the authoritarian setting may overcome to a large extent the attitude of repression resulting from the official situation.

It should be mentioned in closing that the community's attitude towards the offender, adult and juvenile, is an important factor in either lessening or magnifying the limitations imposed by the authoritarian setting. The assumption by the community that once an offender always an offender, once a delinquent always a delinquent, is certainly incompatible with any treatment effort on the part of the official agency. The community tends to stamp the offender as chronic; he is not trusted. When that occurs, much of the work of parole and probation and institutional treatment is nullified. There are, of course, many business organizations whose social-mindedness is exemplified in a willingness to assist in the industrial rehabilitation of former offenders, but unfortunately they are too few in number.

The private social agencies themselves have bizarre attitudes toward former offenders. They look upon them as being not as good an investment for case-work efforts or other

specific services as those whom they term their "normal clientele." This attitude on the part of private case-work agencies is less in evidence since they have been using psychological tools for treatment and have gained a better insight into the treatment of personality ills. The increased responsibility for relief-giving that has been taken on by the public agency, affording as it does more opportunity to the private agency to render case-work services, is also contributing to a change in attitude on the part of private social work. And the law itself is undergoing a change that is resulting in the substitution, slowly, but surely, of chancery for criminal procedures, carrying with it a socialized thinking which is reducing the gap between legal procedure and the therapeutic point of view. At least there are to-day enough leaders in the field of law, of social and psychological orientation, to encourage us in the belief that the legal aspects will be less of a hindrance, as the years go on, to the performance of case-work functions in the authoritarian setting than in the past and than is the experience in too many instances at present.

CAN THE ALCOHOLIC BECOME A MODERATE DRINKER?

ANONYMOUS

IT was June in the year of 1920. I had just returned from Andover and was busily preparing to enter the University of Pennsylvania the coming fall. My older brother had just returned from his first year at Penn, and we were having one of our few serious discussions of the more earnest aspects of life. To my consternation and horror, I was learning from a reliable source that college students, boys of approximately my own age, used liquor, and apparently used it to excess more than often. I was shocked. In retrospect, it does not seem possible that such a statement could have made such a vivid impression, but I resolved then and there that the grape and I would never be friends.

I was vaguely aware of the potentialities of the abuse of alcohol. I had seen the corner drunk, but to me he was of a different world and concerned me no more nor less than did the pickpocket or some other type of minor criminal. Strong drink in any form was strictly taboo in my home, and the question of alcohol played little, if any, part in my thinking, except that I knew that its abuse was disgusting. Furthermore, the "noble experiment" was now getting under way, and soon intoxicating beverages were to be a thing of the past. I did not dream that the time was not far distant when the problem of drinking was to be uppermost in all my thoughts.

To-day alcoholism has become so serious a problem that it is high time the whole matter was brought more openly to the attention of the public and some practicable solution attempted. This is the attempt of a victim to have his say.

It is not necessary to detail the many results of chronic alcoholism. Its associates—loss of memory, insanity, and crime, to say nothing of marital and business troubles, and complete loss of efficiency—speak for themselves. Needless to say, the true alcoholic, if not cured, ends up as a common

bum or a permanent resident of a mental institution, unless violent death mercifully intervenes.

The insidious thing about inebriety is that the disease is no respecter of persons. The most personable, the strongest, are its subjects as well as the weak and the unfit. Fortunately for the former, family ties, education, and previous attainments build up a protecting wall. But this does not last forever!

Unfortunately for the victim, he is generally not overwhelmed by sympathy from his family and friends. In their opinion, the way to quit is to quit, and why doesn't he? They reason that his predicament is the result of a definite act, which could be avoided if he tried hard enough. Were he the victim of some other disorder—and alcoholism is the definite result of an organic allergy—he would be overwhelmed by kindness, and his friends could not do enough for him. As it is, they are decidedly skeptical. The subject of alcoholism is probably the least understood of all medical problems. Unfortunately it is also one of the most serious.

I cannot, nor do I desire to, go into my own case too deeply, but because it is so typical, I will outline it briefly. I took my first drink during my freshman year at college, the night I was initiated into my college fraternity. "One of the boys" sold me on the idea that it was the thing to do in order to become "a good sport." That boy committed suicide in a fit of alcoholic depression about four years ago. That first drink was not memorable. After all, one does not become a drunkard overnight. I was a "social drinker" all during my college days. I had many good times and suffered to some extent the morning after. At the time it never occurred to me to drink in the morning. I could not bear the sight of the stuff. I do not think it affected my scholarship much. In any event, I graduated, not brilliantly, but I did get my degree.

After college, I began to drink more frequently and also to consume a greater quantity at one time. It was about two years after my school days that I took my first drink in the morning. I had heard about "the hair of the dog that bit you," and one morning, after an unusually bad night, I decided to test this theory. I can see now that this morning

was the beginning of the end. By now I was married and the father of a young son, but this added responsibility did not seem to make any difference. Drinking was no longer a minor sport, but a major one. I now drank every morning if I had had anything the night before—and this was the case more often than not.

I can state right here that the true test of whether or not you are an alcoholic is this: Can you, after an evening of drinking, consistently put aside the temptation to take a drink before the close of work the next day? If you can and do, you are not an alcoholic, no matter what other weird results your imbibing may bring about. Once you start to drink in the morning, there is no end to the trail. One or two drinks eliminate the shakes and the jitters. If this is true, surely four or five will create a new man! Then, of course, it becomes imperative to keep up to this peak for all the rest of the day—and to-morrow the story is the same. A truly vicious circle. I have tried all methods. I have decided that I will drink beer only. This results in one of two things—either I force myself to drink enough beer to get drunk, or I tire of this procedure as too slow and change to whisky. I have tried the "wine wagon" with the same results. I have found that alcohol is alcohol, no matter what the medium used, and that enough of it is definitely intoxicating.

Mysteriously enough, I managed to hold my first position for eleven years, but finally my employer rightfully reached the end of his endurance, and at almost the same time so did my wife. Why go into all the details? Happy moments, yes, but terrible hours, too. Unbearable embarrassments, loss of friends, even casual jail—the descent into hell! By this time I was, of course, attempting by might and main to pull myself away from the clutches of my vice. I spent hundreds of dollars with psychiatrists and, on losing my employment in September, 1935, I went away to a private mental institution for a month. This was an impressive experience, but it did me no good. My whole attitude was that this was an opportunity to build up physically, and that at the end of the time I would be able to start all over again—and this time drink like a gentleman. I would never under any circum-

stances get drunk again. I was soon to be sadly disillusioned.

From there I went to New York City and immediately obtained a new position. By now, my drinking habits had somewhat changed. From complete abstinence, I would start taking a few drinks each day, gradually increasing the number. This would go on for four or five weeks, during which time I would carry on with indifferent success in my occupation. Then the morning would come when I would be too ill to go to work. For three or four days I would put myself under the complete domination of alcohol, using it as an anæsthetic, sometimes going to a hotel and scarcely leaving my room except to get another supply of the stuff. Eventually the time would arrive when I would be so weak and jittery that I knew I would either have to quit or die—and I would quit. Although I knew that I should eat at least meagerly during one of these sieges, the thought of food was so abhorrent to me that I ate practically nothing. As I was living alone in a strange city, the final wind-up generally necessitated going to a hospital for a few days. Then I would go back to work sober and repentant—and determined. I would be all right for a month or more and then go through the same process again. My employer stomached this state of affairs for about a year and a half, and then I found myself once again in the ranks of the unemployed.

It was now midsummer. I took my now ten-year-old son to the New Jersey shore and spent a sober and in many ways delightful month trying to figure out just what I was going to do with my life. I knew that first and foremost I must go somewhere where I would be unable to obtain alcohol for a long period of time. I thought of the Maine woods, a tramp-freight cruise, and various other procedures, but finally came to realize that none of them could be the solution, because they could not possibly provide the supervision that would be required.

So I came to what is the finest private mental institution in the country. There are quite a number of us here who haven't the legitimate excuse that we are mental or nervous cases. Here I can build up my health and obtain a new perspective. I have supervision, routine, and restraint. I have friendly advice and consultation with the best psychiatrists

in the country—and best of all I have the time and the incentive to think. Fortunately I am too young to have been impaired mentally or physically. But, make no mistake, alcohol does impair in both respects—and impair seriously. The best available figures show that 40 per cent of insanity has alcoholism as a background. As to the physical side, the facts are well known.

My conclusions? It is paradoxical that such a complex matter can be reduced to such a simple equation. First, we problem drinkers must realize that we can never become temperate drinkers. I am not a physician nor am I skilled in the subject of anatomy, but I do know that we problem drinkers are made differently from the ordinary run of the mill. Our nervous systems are different. We are allergic to alcohol. The "reformed drunkard" who becomes a moderate drinker never was a drunkard in the true sense of the word. The real reformed alcoholic becomes the teetotaler.

Secondly, and most important of all, we must decide that we do not want to be temperate drinkers. This statement is my real theme song. I think that most alcoholics have been convinced at one time or another that they would never achieve their ideal of drinking temperately. Their whole trouble is that it *is* their ideal. And so long as this hope shines forth at the end of the rainbow, they are not strong enough to resist reaching out for it. My downfalls have all been a direct result of this desire. There is a tremendous emotional problem here. Although I am logical enough to know from hundreds of experiences that I can never reach the desired estate of a temperate drinker, *the wish and the will* to reach it are so strong that logic dies and emotion wins. My mind says, "This is all nonsense. I'm no different from my neighbor. I can drink like a human being this time." Then comes the first drink, resulting in a complete let-down of all censors, anger at myself for breaking my resolutions, and a consequent "what the hell" attitude. I have never had any difficulty in understanding my drive to continue to drink after taking the first one. This is psychologically plausible. Even my friends can understand this, but what they can't understand is why I take the first one, when hun-

dreds of precedents have proven that disaster is sure to ensue. I have often said, "I drink to get temporary relief from reality. I seek an escape, and alcohol is the only escape I know." An escape from what? I drank antisocially before I had a trouble in the world. It is perfectly clear to every one that we should build up as pleasant and as happy an environment as possible. This helps in the solution of any difficult problem—but it isn't everything. So long as the alcoholic persists in his admiration of the moderate drinker as his ideal and so long as his desire is to emulate him, he will sooner or later experiment and disaster will result.

The hay-fever victim does not reach for the goldenrod. How can the drinker's ideal be made similar to that field of weeds? It really is simple. I once was a temperate drinker and I remember all about it. I have talked and lived with temperate drinkers. It should be stated here that I do not consider the occasional imbiber of a cocktail in this category. He is not a drinker at all. The temperate drinker is one who drinks sufficiently to have some qualms about the wisdom of his manner of living, yet who does not fall into the category of the alcoholic or problem drinker. Make no mistake—I have no quarrel with him. He has his great moments. Many a fine friendship would never have been formed except for the use of the "cup that cheers," but it doesn't average up. Such a drinker subjects himself to a serious lack of efficiency, sleeplessness, and numerous other disagreeable situations, varying, of course, with the extent of his drinking and his physical make-up. He is rarely in a state of complete physical well-being. He is like the mother who is about to bear a child and who swears by all that is holy that if she ever lives through her present experience it will be her last. In a few weeks she has forgotton her agony and thinks that a little sister would be nice. It is human nature to forget the grief and to remember only the present experiences.

Furthermore, I have no desire to change my type of associate. In the class of my standard of living, the drinker is not only in the majority, but he constitutes the cream of the crop. If he can take it, the decision is his and his alone to

make. But he isn't smart. If he applied the logic to this proposition that he applied to his business, he would make a different choice.

So what is the Utopia that I have been seeking all my life? I know now that it is nothing but a myth. It is nothing that I want—and I am going to refuse to seek it further.

Several months have elapsed since I made my decision to seek asylum, and I am about ready to try my wings. I am going to turn my weakness into an asset. I don't dare to be a temperate drinker. But best of all, I don't want to be. If this be whistling in the dark, I choose to whistle.

RESULTS AND PROBLEMS OF GROUP PSYCHOTHERAPY IN SEVERE NEUROSES *

PAUL SCHILDER, M.D.

Research Professor of Psychiatry and Clinical Director, Psychiatric Division, Bellevue Hospital, New York City

THE problem of adequate psychotherapeutic care for neurotic patients who frequent the out-patient departments of public hospitals is an urgent one. Psychoanalysis is undoubtedly an efficient therapeutic weapon, but it makes great demands on the time both of the physician and of the patient. Thus it has become in our economic structure a method employed only for the wealthy. In addition, the general trend in psychoanalytic technique is to prolong the treatment; indeed, daily treatments for two or three years are not considered unusual. If psychoanalysis is the best treatment available at the present time, the community should utilize it; but if this be impracticable, experiments should be conducted in an attempt to find an alternative. In public hospitals surgical cases receive care that is in no way inferior to that given the private case. It is our social duty to set up the same standards in the care of the neurotic patient.

Psychoanalysis is based upon a definite and well-studied relationship between two human beings—the analyst and the patient. Other human beings appear in a way suggestive of ghosts during the analysis. The patient confides in an analyst whom he trusts not to divulge his secrets. To be sure, the analyzed person, reëxperiencing his past life with the analyst, finally finds his way back to the social continuum in which he lives. There is no doubt but that the transference situation, carefully as it has been studied, is still full of pitfalls. When one considers that isolation and secrecy are basic factors in the psychology of the neurotic, one is tempted to discard both of them in the therapeutic situation. In group

* Read at the Ninety-second Annual Meeting of the American Psychiatric Association, St. Louis, Missouri, May 7, 1936.

psychotherapy, a number of patients are seen simultaneously by the physician, and each patient is aware of the problems of the others. A second physician may join the group and add his interpretations.

A year and a half ago, I began an experiment in group psychotherapy in the Out-Patient Department of the Psychiatric Division of Bellevue Hospital. Up to the present time about fifty cases of severe neuroses and mild psychoses have been treated. Only severe cases have been taken into this group. Most of the neuroses were of long standing and had been previously treated by other methods. A definite therapeutic plan was followed.

Human beings live not only in a group—they live also as comparatively independent entities. A therapy dealing only with the group would be as one-sided as a purely individualistic treatment. Every patient was seen individually before he joined the group, and these personal interviews were continued throughout the treatment. The groups meet once or twice a week, from two to seven patients participating. This type of therapy emphasizes the leadership of the physician, through the mere fact that he directs the group. Patients should have insight into this relationship. They should not be blind believers. The physician should be not an authority, but a leader, and it should be clear that his leadership is based not upon any intrinsic superiority, but upon the particular task to be solved by the group. Basically, he is a fellow human being confronted with the same problems as any other member of the group.

The various forms of psychotherapy emphasize specific sides of inter-human relations. If a physician gives orders to patients without giving them any insight into the nature of these orders, his therapy is based upon the necessity for authority in human life. In hypnosis, therapy is based upon the human relationship of erotic submission. In cathartic hypnosis, the patient is forced into insight. Again, one may treat a patient as a sensible fellow human being with whom problems can be discussed. An attitude of friendly helpfulness may be added.

In psychoanalysis the semblance of an impersonal relationship may be insisted upon, but the patient is in reality in a

state of submission which is more or less one of complete surrender. In the further course of analysis, insight accrues with the revival of significant childhood attitudes. The therapeutic situation, if in any way valuable, is based upon a human relationship of fundamental importance. Hypnosis, for instance, which stresses submission and surrender to a magic power of love, reveals at least one important side of human relations. The technique immediately reaches a higher level if the patient has insight into this. The part truth of the hypnotic attitude and of any psychotherapeutic attitude should be seen at its real value. The final aim of psychotherapy can only be insight. Psychoanalysis comes nearest to this goal. Insight means more than verbalization. It means the ability to see the structures of the real world and to act accordingly.

Psychoanalytic insight was utilized in this group treatment. In every case the life history of the patient was discussed and elucidated in detail and early infantile material was particularly studied. A written report was asked of the patient after he had gained partial insight. Not only had he to write his life history, but he also had to discuss his relationship with father, mother, siblings, and nurses. In addition, a report of his sexual development was required. Further reports were called for according to the needs of the therapeutic situation. Dream interpretation and so-called free associations were used both in the individual treatments and in the group treatments. Sexual development was studied as completely as possible. Besides an historical approach to the personality, the ideologies of the patients and their general orientation to life were investigated. No individual can be understood unless his objective is known—his goal and his life plan. One must know his expectations for the future. The individual, too, must gain deeper insight into his own needs and wishes. He must learn to understand the social setting and his social and sexual ambitions.

These basic problems may be formulated briefly as follows: (1) body and beauty; (2) health, strength, efficiency, superiority, and inferiority in a physical sense; (3) aggressiveness and submission; (4) masculinity and femininity; (5) the relationship between sex and love; (6) the expectation for the

future; and (7) the meaning of death. Particular attention must be given to the language in which the patient expresses his attitudes toward these basic problems. Certain phrases are very often used in order to enable the patient to hide his real attitudes from himself. Phrases not fully understood in their true meaning are very often found at the turning point of an individual's life. It is necessary that the individual's conscious and unconscious goals come into full light with insight. Modern psychology has all too often forgotten the social nature of human experiences. I have been able to show that even the experience of one's own body, the body image, acquires its final expression only in a continuous interplay with the body images of other human beings.

Hartshorne has justly emphasized the social character of every sensation. Any problem of money, occupation, and sex that may be met has its true meaning only in a social setting of which it is a part, and cannot even be thought of apart from this social setting. Obviously, then, the significance of any detail of an individual life history will be clearer if it is brought forward in a group and appraised by a group. In one discussion, for example, a patient remembered an attempted sexual assault against his sister. It was astonishing how many members of the group recalled similar experiences in their own lives, so that a correct appreciation of such an event became possible. On 'Mother's Day' one of the patients brought forth bitter complaints against his mother, who had curtailed his freedom, had not given him enough love, and had had a sex life of her own. This outcry provoked a whole series of similar associations from the other patients. The deeper social meaning of the Œdipus situation revealed itself, and the patients experienced their specific attitudes merely as variations of a general attitude. The relief patients experience when they no longer feel excluded from the community because of urges and desires that society does not openly tolerate is remarkable. To be sure, in the strictly analytic situation, the analyst offers a like relief, but there he is merely the representative of a group, whereas in the group treatment the patient actually experiences the breaking through of similar or identical impulses in others. Group treatment is in this respect a step nearer to reality.

Feelings of guilt result from sexual drives and actions, and from aggressiveness. Both seem to excommunicate the individual from a society that sets up for him a system of ideals that cannot be fulfilled. Mothers are supposed always to love their children and children are expected always to love their parents. There should be no destructive impulses against any one; good deeds from the individual are not enough—the demand is also that he think only good thoughts. Morally we live in a state that punishes not only actions, but thoughts as well. In a general way we feel that the authorities of a country should permit liberty of thought. But the unwritten ideologies and prejudices, the demands of misunderstood morality are much more tyrannical than written laws, since the former punish for thoughts. Thoughts must come out into the open quite in the same way as ideologies if individuals are to be liberated from their feelings of guilt.

In a group, the patients realize with astonishment that the thoughts which have seemed to isolate them are common to all of them. This enables them clearly to see their aggressive instincts and helps them to understand that aggressive instincts and social conduct are compatible.

The thoughts and ideologies of one patient become the common medium for the group in their continuous emotional interplay. Most of the threads are united in the person of the analyst, who enters into the discussions, the language analysis, and even into the free associations of the patients. The definite interpretation of a symptom or of an action of a patient is the work not merely of the analyst, but of the whole group.

The phenomena of positive and negative transference to the analyst are not less outspoken in the group than in the usual psychoanalytic treatment. They express themselves in generally known terms. The reaction of one patient to the transference situation of another patient is very often remarkable. The patient in a state of positive transference feels a need to defend the analyst against the negative transference of another patient. In the negative transference, the group particularly stress that the physician is not sufficiently interested in their fate, that as a public employee he must

spend his hours with them regardless, and that he is less interested in the fate of the patients than in the scientific problems they offer. Very often discussions of problems of this type have a very important effect upon the fate of a group. They can be shown that nobody has the right to expect the complete emotional surrender of another person —that the other person has to live his own life even if he does happen to be one's father or one's relative or one's physician.

The patients brought together in one group are not particularly selected, but men and women have been treated separately. It has been my general plan to bring every patient who is at a given time under treatment into contact with the other patients of the same sex. I hope that it will be possible to have persons of both sexes in the same group when we have gained a deeper understanding of this method.

The method I have described will not escape the reproach of being too intellectual and putting too much emphasis upon the factor of insight. Skepticism may be increased when I confess that I do not refrain from using an elaborate system of questionnaires. These contain such questions as what the patient remembers about his father, what he thinks about him, and what phantasies he has had about him. These questions are concerned not only with the sexual problems relating to the father, but with every phase of the father's life, as whether he was considered strong, healthy, gifted, clever, successful, and so on. Similar questions are elaborated about the mother, siblings, nurses, and teachers. A further series relates to ideas about one's own body. Others probe the castration complex, masturbation, intercourse, breasts, urination, defecation, the attitude of the family and of the patient toward disease, food habits, and so forth. A different set sought to discuss aggressiveness and attitudes toward death, the opinions the individual has about himself, his goals in life, and, finally, the general attitude of human beings toward one another. At least one should try to discover the basic attitude of an individual in the following spheres of experience: (1) the need to love and be loved (according to Watson, love means stroking); (2) the tendency to maintain one's own support (in childhood, against gravitation); (3)

the tendency to maintain the integrity of the body (sudden noise, sudden impressions are a threat in this respect); (4) the tendency to eat and drink and to get as much property as possible, to acquire and to retain; (5) the tendency to expel what the organism can no longer use and to push away that which is threatening; (6) the tendency to handle and to destroy objects and human beings and to get an insight into their structure; (7) the tendency to help others in the pursuit of the same aims.

This is a reformulation of the problems that we considered as most important in an individual's life.

One of the discussions arising out of the individual problems of the patients is here reproduced in a slightly altered form.[1]

B., twenty-one years old, had a severe social neurosis which caused him to withdraw from contact with others and to suffer from severe feelings of inadequacy; his speech was actually hesitant. He stammered when he checked impulses of rage directed against those who he believed were ridiculing him. Excessive ambitions had developed to overcompensate for his sense of being threatened. In school games he did not want to be on the losing team. He was interested in auto races and in all speed races involving motor-driven vehicles, seeming to feel that their force was added to his. He did not like sports in which he was dependent only upon his own ability.

E., twenty-one years old, with a basal metabolism of minus 23, had felt that he had no energy and no drive. Accordingly he would exert himself too much, feel bewildered, and then give up almost completely, until he really had become inefficient. His sexual energy seemed to have little vitality. There were no sex phantasies or sex impulses when he came for treatment. In spite of a rise in the basal metabolic rate to minus 8 under the influence of thyroid medication, he did not change until psychotherapy had given him insight into his problems. Sexuality then awakened. The question is, Where did he get the energy with which to drive himself forward? One may draw the conclusion that human beings should gayly acknowledge their shortcomings. They should be taught neither to overcompensate for them nor to brush them out of consciousness. Every one should be aware of the necessity of having shortcomings. The ideal of general efficiency and of striving to be blameless is a wrong one. If one is a minus variant as a personality, one should accept the fact. Minus qualities in ourselves and in others make us human and the attempt to be perfect only makes us into caricatures.

F., twenty-one years old, an anxiety neurotic with the fear of sudden death, had no problems of this kind. He lived in an emotional attachment to his mother and brother and expected protection from them

[1] I have added the brief remarks on the history of each patient. Every one in the group knew the histories of the others.

against the dangers connected with his own lack of strength. It did not matter whether this attachment to the mother was sexual or not, but it was important that he have no inferiority feelings in the ordinary sense. There is no reason to believe that there is only one fundamental problem lying at the base of neuroses. One should evaluate life situations as human problems in their varieties of expression.

C., twenty-four years old, suffered from inferiority and guilt feelings, because of obsessional sex drives against children and men, and obsessional aggressions, such as kicking and pushing. He had been forced into this situation by his mother, who overpowered him. If there were feelings of inferiority, they were the result of a complicated sexual development. He was very much frightened by his impulses, whose strength he overestimated. Perhaps too much is expected of us in a moral way, and it should be acknowledged that there are impulses which go against the standards of society. One should be lenient to one's own morality, especially if it harms no one. It is probable that tolerance of one's own impulses does not strengthen them, but reveals them as inefficient and weak—that is, if they do not fit into the structure of the personality and into society.

In the case of W., nineteen years old, the fight against the father and the protection of the mother against the father (also sexually) were prominent. In W.'s attempt to substitute for the father he cultivated intellectuality. He denied himself sexuality because he condemned it in his father and mother. Since he wanted to convince himself and others that he was superior to his father, he was concerned only in having others acknowledge his superiority. He was shy and self-conscious with people who he believed gave him exaggerated attention.

Modern men suffer from the idea that they should be perfect. They expect perfect health and are unduly perturbed and excited by minor symptoms. W., for example, has palpitations when in bed. One should have patience with one's own body, and not be afraid of being weak and tired. People want to be highly efficient, to show speed and energy, when they should have the courage to be slow and adynamic. It is easier to be tolerant toward one's self if no comparison is made with others. Humanity should be considered as consisting of varied types and those who are not highly gifted are still an important part of society as a whole. The imperfect human being is needed as well as the one approaching perfection and one should be tolerant toward one's own stupidities. The stupid person is more than a mere background for the intelligent.

If humans ask of themselves speed of movement and of speech and strength, why should they not ask to be beautiful in all the parts of their bodies? The perfection sought for oneself is demanded of others, and intolerance ensues. This intolerance is greater toward the members of one's own family and they are expected to be ideal figures without blemish. Of course, they can't live up to these images. Parents have to pay dearly for every perfectionistic ideal they put into their children's minds. The child will soon measure his parents against the ideals implanted in him and find them wanting. When parents teach children suppression of sex, children retaliate by fighting against the sexuality of their parents. Asexuality belongs to the perfectionistic ideal. Sometimes it is expected that sexuality shall awaken only at the conventional

signal. Perfectionistic ideals exist not only for physical functions, but also for one's strivings, and can be positive as well as negative. They demand, for instance, from one's self and from others (1) absence of hate, (2) a continuous flow of love toward one's love object, (3) continuous sexual impulses toward a socially acknowledged love object, and (4) absence of promiscuous impulses or sexual impulses.

The foregoing paragraphs summarize the record of one group treatment. The objection of intellectuality may again be raised. The account given here does not indicate how closely these general remarks were related to definite experiences of the patients. The discussion shows in detail how the patient developed his attitude. It should not be forgotten either that this is only one of the phases in the treatment. The truth of the formulation is considered only as partial truth which must be completed by the other aspects of the situation. In connection with this specific record, for instance, a discussion would be necessary to show how the individual fits his impulses into society.

In modern psychopathology, the difference between intellectual and emotional processes is too greatly emphasized. To be sure, though it has never been formulated, there is an underlying assumption that intellectual processes are pale and without strength, and this at a time when everybody speaks of the personality as a whole. Attitudes express themselves in thinking as well as in emotions, and emotions also have goals and aims. A separation of intellect and emotion is artificial and is justified only if one considers them as two sides of the unified attitude of an individual, one or the other facet scintillating more strongly according to circumstances.

One might further object to the procedure as recorded because it involved a more or less definite stand on the part of the physician, while psychoanalysis has attempted an attitude of neutrality on questions of morals and values. But as I have stated, Freud is deceiving himself in holding that he is purely scientific and has no "*Weltanschauung.*" Psychoanalysis has in fact a definite attitude toward certain moral problems. A body of definite knowledge contains in itself a definitely moral point of view and invites definite actions. One should know this. If one is practicing psycho-

therapy, and especially group psychotherapy, one should know what to expect from life.

As one would suppose, group psychotherapy is especially effective in cases of what I should characterize as social neuroses. These are cases that do not feel comfortable in the presence of others. They feel that they cannot concentrate, they cannot think, or they are merely embarrassed and uncomfortable. Physical symptoms, such as palpitation or discomfort in the gastrointestinal tract, may be present. Sweating, blushing, awkwardness in movement, may become obvious signals of this discomfort. The individual feels that he is the center of attention, that not only is something wrong with him, but that others realize it. Every object becomes, in this respect, an important object on a sado-masochistic level. To be seen and to be observed means to be hurt and to be pushed into an inferior position.

Twelve cases of social neurosis have been treated by our group method. Three can be considered as cured. In the case of E., mentioned above, sexuality, which had been dormant, appeared in spite of the organic background in the situation. Only two cases showed no improvement. The remaining seven were decidedly improved, and some of them are still under treatment.

In one case of stammering, the stammering was not overcome, but there was an improvement in social attitude.

Nine cases of obsession neurosis have been treated. There has been no complete failure in this series. Two severe cases were cured. In a third an involuntary bromide intoxication led to a complete disappearance of the symptoms. Two cases with slight encephalitic signs showed a very decided improvement. Two other cases, both severe and of long standing, were mildly improved; both were still under treatment at the time this paper was written. The two remaining cases improved to the point where they are adapting well to society and enjoying themselves.

Of three cases of anxiety neurosis, two were cured and one was improved.

Of four hysterias, two were cured, one was unchanged, and one ceased treatment too early.

Three cases of hypochondriasis were not influenced by the treatment.

Two cases with organic vegetative symptoms adapted better, but the organic symptoms did not disappear.

Of three cases of character problems, one was discharged and was well adjusted at the time of writing; the other two were considerably improved and are still under treatment.

Of six depersonalization cases, one was cured and one decidedly improved; one who did not come back for treatment was slightly improved at the time the treatment was broken off. Three were unimproved. One of these three was a schizophrenia and another a depression.

Two cases of depression (in addition to the depersonalization case) were unimproved. One of them committed suicide. The family had been warned.

Among four cases of schizophrenia in which treatment was attempted (besides the depersonalization case) two cases were not influenced. One case, in which the diagnosis was dementia simplex, adjusted much better. The fourth case completely recovered, and was socially and sexually adapted at the time of writing. Fear of homosexuality and homosexual ideas of reference had been in the foreground. I was in no doubt about the diagnosis of schizophrenia when I started the treatment, which lasted several months. The possibility of an atypical depression might have been considered, but I adhered to my original diagnosis.

Many of the cases treated in this group could not have been treated individually even with the classical analysis. They reacted only in the group. This is especially true of social neuroses.

This is only a very brief report of the experiment. It is difficult to judge therapeutic results after so comparatively short a time, and perhaps I have been too optimistic. If this should be so, it lies in the nature of the psychotherapeutic approach. It is probable that not all of the results are permanent and there may be relapses sooner or later. But I believe, as do the patients, that they have been helped to get a better orientation to life. I have had an opportunity to compare the results of this method with those of others. In

some cases the approach is preferable to the strictly analytic technique, and again there are cases in which the psychoanalytic approach is doubtlessly superior. However, one will have to learn. A definite technique has been utilized. I hope that this technique can be taught and can be learned.

Summary

A method of group psychotherapy has been developed which attempts to give the patient a deeper insight into his individual life history, his ideologies, his problems, and his expectations for the future. The basis of this treatment is a written report of the patient concerning the various phases and aspects of his life and of his relationships to the persons in his world. Sexual development is elucidated. Dream interpretation and free association are utilized. The patient must understand how much he has been under the influence of merely verbal formulations in his life plan. In individual interviews and in group discussions various aspects of the personality come into the foreground. The analyst as a member of the group is compelled to greater activity. The patients gain a new direction and new orientation in life.

The therapeutic results so far are promising, especially in the social neuroses and obsession neuroses. This truly social method, though it, too, requires much time, enables the physician to treat a relatively large number of cases and to help them in the development of their personalities.

AN EXPERIMENT IN TRAINING NURSES TO HELP MOTHERS IN PREVENTIVE MENTAL HYGIENE *

JULIUS LEVY, M.D.

Director, Bureau of Maternal and Child Health, New Jersey State Department of Health, Trenton

MUCH progress has been made in improving the care of the mentally ill, and in bringing about the earlier diagnosis and treatment of psychoses, since Mr. Beers wrote his epoch-making book. The term, "mental hygiene," has, to a very considerable degree, come to represent the thought and efforts that have gone into these achievements. We have long felt, however, that the words should, to a much greater degree, connote prevention rather than amelioration or treatment or even earlier diagnosis. The present paper is an account of an attempt to incorporate mental hygiene in this sense into a maternal and child-health program.

The title of the paper was carefully worded to indicate clearly the many problems involved in such an effort.

First, in regard to the aims of the experiment, it may be said to have three:

1. To determine whether mothers really can be helped to *understand* child development in the mental-hygiene field as well as in the physical field, to *appreciate* the value and importance of their own attitudes and methods of handling their children, and to *apply* what they learn in the *actual bringing up* of their children.

2. To determine whether public-health nurses can be educated to appreciate and understand mental-hygiene principles and their application sufficiently to help mothers carry out in their daily routines what is important for wholesome parent-child relationships. The word, "help," in our title, rather than "teach" or "train," in relation to mothers was chosen advisedly. There are types that can learn certain desirable procedures in parent-child relationships only by

* Presented at the Special Session on Mental Hygiene of the Sixty-sixth Annual Meeting of the American Public Health Association, New York, October 5, 1937.

means of categorical orders. This statement applies equally well to the physical side of child hygiene. With this group one cannot hope to accomplish very much in the way of giving them a better understanding of the emotional and mental needs of their children. Perhaps certain commands—such as, "Do not frighten children by threats"; "Do not nag"; "Do not inflict severe corporal punishment"—may to some small degree be helpful, but our chief interest is with the larger group of mothers who can be helped to understand themselves and their children. From this understanding comes a desire for further instruction and guidance in the proper parent-child relationships which will influence conduct and attitudes.

3. To determine whether, through this teaching of mothers by public-health nurses in the course of their routine child-health work, it is possible to contribute to a happy and wholesome personality in the child, and to prevent many of the common behavior problems, maladjustments, and delinquencies of later life.

Right here I suppose we should introduce our concept of mental hygiene. Many who, in their definition of mental hygiene, have gone beyond the development of better institutions for the mentally ill or better care or even earlier recognition of psychoses, are still inclined to include delinquency and the behavior problems of school-age children. To us mental hygiene is the art of trying to keep well emotionally and mentally. Just as physical disabilities—malnutrition, deficiency disorders, disease, defects, and deformities—have their inception in early infancy or even in the prenatal period, so that effective child hygiene must begin at this early stage, so we maintain that, to yield the best result, mental hygiene also should be applied in these early formative periods.

We are aware of the view of certain psychiatrists that a mother's conduct is determined largely by her own feelings of guilt, fear, or shame, and by anxieties, frustrations, and conflicts. Their position is that didactic advice and instruction are not likely to help mothers very much. As a matter of fact, some psychiatrists indicate that the only time for effective teaching is at the time of crisis. It is our assumption, however, that guidance and advice will lead to a better handling of children. This should result in fewer personality

difficulties, and in many instances in their entire prevention. Many mothers fail to bring up their children wisely because they have never learned how to be good parents. Of course, we are using the word, "good," as meaning competent. Parents need special training just as do people who work in other professions.

I have thought it desirable to indicate at the outset that we recognize the number of problems involved in this experiment. Perhaps we can proceed now to describe what we are trying to accomplish and the methods that we are following. From a rather extensive experience with the physical side of child health, in which twenty-five years ago we emphasized the prevention rather than the early detection or better treatment of disease and defects, we have come to feel that in mental hygiene, too, the effort should be to further normal emotional and mental development. In this way one will prevent to some extent the acquisition of undesirable habits and feelings, emotional and mental disturbances, conflicts, and frustrations. For this, the same method is followed as in the physical field. The normal mental and emotional development of infants and children is explained to mothers, and then, just as we advise them how to feed children in order to maintain the optimum of nutrition, so we try to indicate how infants and children should be handled to obtain the optimum of personality development. Situations and certain phases of conduct have been anticipated for mothers, so that through understanding they will be better able to take the right attitude toward their children's behavior and to use desirable methods of dealing with it.

For instance, instead of waiting until a child refuses to eat his food and then telling a mother what she should do about it, our method is to tell mothers that infants at one time or another will refuse their food or will show a lack of interest in it, and to advise them as to what their attitude should be at such a time. In the same way, instead of waiting until a mother comes to tell the nurse or doctor or psychiatrist that her child cries continuously, we tell mothers that their children will cry, help them to understand the meaning of crying, and explain to them what their attitude should be when their infants cry. Instead of waiting until

a mother spoils her child during some temporary illness or convalescence, we would anticipate what we know from experience is likely to be her conduct and attitude by explaining to her in advance that the child at some time or other is going to be ill or indisposed and will generally act in a certain manner, and that if she wishes the child to maintain the good habits she has succeeded in establishing before the illness, she should conduct herself in a certain way during the illness. For this method we have coined the phrase, "anticipatory guidance."

This in no way differs from the methods used in dealing with the physical aspects of child hygiene. When we started that work in 1912, it was our custom to try to reduce the high infant mortality by distributing pasteurized milk in the summer and by increasing our staff of doctors and nurses so that we might take on the work of advising mothers as to the care and treatment of summer diarrhœa. We pointed out that the effective way to prevent infant mortality from summer diarrhœa was so to feed babies from the very outset that they would not develop gastrointestinal disturbances. I give this illustration of our attitude in the physical field, so that those who may be inclined to question the validity of our procedures in the field of mental hygiene will at least know through what experience they were acquired.

Enough is known of the usual conduct of infants and of parents to enable us to anticipate situations. We know that at some time an infant will refuse his bottle—his food; that he will refuse to go to bed; that he will lie on the floor and yell; that he will cry when his mother goes out. We know that some babies are shy and retiring, and others egocentric and aggressive. By discussing with mothers these and other situations before they arise, by repeatedly stressing the general principles of behavior more or less involved in these situations, by repeatedly helping mothers to acquire and to maintain desirable attitudes, emotional and physical, we believe that more desirable behavior patterns will develop, that many conflicts will be avoided, and that wholesome and natural activity will be made possible.

Training Nurses.—The task of training nurses for this

work has been placed in charge of a person whose principal experience has been with the Child Study Association of America and who holds a graduate degree in pedagogy and sociology. She is not a physician or a psychiatrist. I mention this point because, for the purposes we have in mind, I believe it is important. Her title is "adviser in parent-child relationships." By this I wish to indicate that we are not attempting to deal with psychiatric problems. We are not trying to train nurses to solve any behavior problems. We are trying only to prevent such problems by early anticipatory guidance.

Classes have been arranged in coöperation with Newark University under the heading, "The Understanding, Care, and Guidance of Children." The physical aspects of child care have been properly incorporated into the course, so that nurses will learn that practically all phases of so-called physical child hygiene carry with them the opportunity for instruction in what we call mental hygiene. The syllabus of the course is available. Most of the nurses have taken courses for two years.

After the nurses have become somewhat familiar with the concepts of preventive mental hygiene, the adviser in parent-child relationships spends a day or two with each nurse in her own field, accompanying her on her routine of unselected visits. Again I emphasize the point that we do not select for the adviser families whose children present behavior problems. It has been necessary persistently, continually, and everlastingly to stress with the nurses that the aim of this training is not to help them solve behavior problems, but rather to help them, through broad understanding, to prevent the development of such problems.

Let me take the opportunity here to mention a by-product of the introduction of a mental-hygiene adviser to the staff. Many nurses have become aware of their own attitudes, drives, and prejudices as these have affected their work. Many, through a better understanding of the emotions and behavior of the mothers with whom they work, have become more efficient in their general child-hygiene work. A number, through the application of mental-hygiene principles to diffi-

culties in their own families, have made desirable readjustments. Others have been helped with personal difficulties by consultation with the adviser in mental hygiene.

To explain how the nurse carries out this teaching, perhaps I should indicate the general plan of our work. There are now in New Jersey about 200 nurses under the supervision of the Bureau of Maternal and Child Health of the New Jersey State Department of Health. Each has a limited district, in which she visits newborn babies from birth and as many expectant mothers as she can find, continuing with the supervision of the pre-school and, in most instances, the school child. She visits these families at least two or three times in the first month of the infant's life, during the first year at least once a month, and in the next three years about once every three months. She has an opportunity, therefore, to guide the mother from the very outset, and through repeated, regular visits to deal with the development of the child month by month. This to my mind is absolutely basic to any plan such as we are developing in mental hygiene. If the nurse's visits are irregular or occur principally in connection with sickness, I do not believe that preventive mental hygiene, as we are conceiving it, can be carried out or can even be attempted.

You may be interested in more detail regarding the education of the nurses. In addition to didactic lectures and discussion periods, the nurses are taken to nursery schools and juvenile courts, and attend at least once a staff conference of one of the mental-hygiene clinics under the Department of Institutions and Agencies. This is done to give them an understanding of the difficulties and intricacies of dealing with actual behavior problems and delinquencies, and to help them realize that many of these difficulties could have been prevented through the proper handling of the children from early infancy. A bibliography has been prepared, and the nurses have been required to read a number of the books recommended. Furthermore, a number of pamphlets on child development and mental hygiene have been carefully selected and two of these are sent the nurses each month. The adviser in parent-child relationships conducts a discussion group with the district supervisors, and at least twice

each year with the entire group of nurses under each district supervisor. The district supervisor then conducts each month a discussion with the nurses on the content of the two pamphlets they have received.

During the past year the adviser has kept a rather interesting record of her visits with each nurse, describing the types of family the nurse had to deal with and the opportunities offered for carrying on preventive education. She has, of course, met all kinds of family. In a certain small percentage, on account of the mentality of the mother or her emotional complexities or because of the economic or social conditions surrounding her, it was almost impossible to attempt anything in the way of mental-hygiene education. On the other hand, many situations are recorded in which this teaching may be helpful, even though evidences of improper handling and development have already appeared. We should like to emphasize also at this point that many of the behavior patterns of children listed below are not maladjustments, but merely phases of development. Homes have been found in which the following situations are present:

1. Babies who have learned to get their own way by refusal to stay alone, by crying to be picked up and held.

2. Toddlers in conflict with mothers because of the failure of the mothers to understand a child's natural curiosity and need for activity; because of the mothers' placing their own convenience and comforts above the needs of the children.

3. Children who have become restless and overactive as a result of the excitability and inconsistency of their mothers, or a tense, noisy home atmosphere.

4. Children who are shy, timid, or fearful because of severe punishment, threats, fearful home atmosphere, or constant discouragement and criticism.

5. Children of pre-school age who show by their conduct that they feel themselves rulers of parents and home, and desire constantly to be noticed and in the limelight, always getting their own way and everything they want, and realizing the intense concern of their parents about them.

6. Children with eating, sleeping, and toilet problems due to poor habit training or to poor parent-children relationships.

7. Children who have no toys, companionship, or play with other children because of the mother's failure to understand these needs or because of the mother's fears.

8. Children who are jealous of each other because of poor handling at the time of birth of siblings, or because the parents have favorities or make comparisons.

We find *special situations,* also, in which there is danger that the child will be spoiled or his normal personality development prevented:

1. Where the child is an only child.
2. Where a baby is born after the other children are already of school age.
3. Where a baby is born of opposite sex to that of the other children in the family.
4. Where a baby is born after a brother or sister has died.
5. Where there have been illness and convalescence of the child.

These situations are frequently improved by helping the mother to understand (1) the nature and developmental needs of children; (2) the effect of her own emotional life on her child; and (3) the value of desirable parent-child relationships.

These situations give us also the clue to our anticipatory teaching—show us what to teach mothers so that they may be prepared to meet the situations should they arise.

The work has been going on now about two years. The nurses have shown an increasing interest and have expressed the opinion that it has helped them immensely in their regular child-health work. I hope it will help also to direct attention to the great opportunity that exists for applying the principles of mental hygiene at the time when they can be most effective—the very beginning of life.

KEEPING HAPPY ON THE JOB*

A. R. HERON

Executive in Charge of Industrial Relations, Crown Zellerbach Corporation, Portland, Oregon

THE discussion of the topic assigned to me is difficult in a group whose interests are so varied. Some of us are workers, skeptical of the possibility of any sincere attention to the subject by employers. Some are employers, suspicious and resentful of the approach of the agitator who promises happiness to those who will respond to his appeal. Many of us are what we like to call practical people, contemptuous of the ability of scientists or theorists to understand, let alone help to solve, the problems of everyday, practical living. Many are students of the social sciences, scornful of the selfishness of those who consider themselves the practical men of industry.

Almost every one knows more about the problem from one approach than any one else here—and by the same token, knows less about it from all other approaches than any one here. Humbly and honestly, I present myself as knowing less about it from every approach than any one of you. For that very reason, my remarks will reveal a vacuum of unanswered questions, into which each of you can direct his own contribution of experience or knowledge or theory.

Will you deal charitably with me as I borrow words from your particular vocabulary, and probably misuse them? Whether you are a trade unionist, an employer, a teacher, a social worker, a political economist, a psychiatrist, a psychologist, an engineer, you may find me using words that are your special property. Please realize that we agree completely that when I use your vocabulary, I do not know exactly what I am talking about. But I have no special vocabulary of my own. And so please let me try to use the words that are yours, in the hope that in the discussion that

* Presented at the Business and Industry Day of the Oregon Mental Hygiene Society Institute, Portland, April 14, 1938.

is to follow each of us will have some question to answer, and each in his own tongue.

The subject of the evening is broadly and wisely phrased. It does not suggest that any of us is concerned with keeping some one else happy. It seems to suggest that it is an individual problem facing each of us—to keep himself happy. But it does have one very significant limitation and assumption. We are discussing "keeping happy *on the job.*"

By this limitation we avoid the immediate problems of leisure, idleness, unemployment, disability, retirement. By this assumption we have a premise—the assignment of each one of us to a job. Does this imply that it is harder to keep happy on the job than off? I think not. Does it imply that the possession of a job, an outlet, an activity, is the first essential to keeping happy? I think so.

Even with this limitation of our subject, we have still diversity of approach. The pursuit of happiness is as old as life. Each of our varied approaches is as old as the social or economic position in which, as individuals, we stand. Let us briefly view some of our approaches.

As an individual, each of us has a desire to achieve his own happiness. In the sense in which each of us is a worker, each on his job, this desire for our own happiness belongs in our discussion to-night—is, in fact, the heart of it. What does it take to keep you happy on the job? Does it take wealth, and luxury, and beauty, and the praise of your fellow workers? Does it require anything that must be attained at the cost of the happiness of some one else?

As an individual, every intelligent employer—even every merely smart employer—desires the happiness of his employees as workers on the job. He may desire it for the purely selfish reason that it will help him to attain his own happiness by making his establishment more orderly, more productive, more profitable.

As an individual, every inactive capitalist desires happiness on the job for the workers in the enterprises where his capital is being used. He goes beyond, and hopes for the reasonable happiness of all workers on the job. A happy population is not a threat to the *status quo*. A nation of individuals "happy on the job" will not overturn the

economic order and thereby destroy his comfortable life program.

As individuals, some people have what one of our leading students has described as the "Jehovah complex"—an exaggerated sense of duty to make others happy, to be a Santa Claus, to be a benevolent fairy. It contributes to the growth of one's ego and one's sense of superiority, and thereby brings to such an individual the kind of happiness his nature craves.

There are a few individuals—and probably most of us to-night would like to class ourselves thus—who have a purely philosophic social view, a conviction that happiness of the individual is the warp on which the evolving pattern of the new society is being woven.

Most of these roads are very old. Perhaps none of them is straight enough or wide enough to reach the goal. May we not, in our day, hope to see them merge? No matter why we want it—no matter whether we are narrowly selfish, or selfish in the enlightened way we choose to call altruistic—the end of the road is keeping happy on the job. We cannot have a social and industrial order that gives us the personal right to the pursuit of happiness and denies it to others.

Therefore, for ourselves, and for the world of other workers who in their thinking are "ourselves," what is it that is required to keep happy on the job? What external handicaps must be removed, for us and for them? What external assistance must be sought, by us and by them? What internal understandings and adjustments must be accomplished, by us and by them?

Our subject has assumed that there is a job on which to keep happy. But some things about that job cannot be merely assumed. There are certain characteristics that we must have in any job before we can keep happy in it. What are they, in our individual cases?

Must it be a congenial job, in the sense of being the work of our first choice? I know ministers who are happy as representatives of labor unions. There are trained labor representatives who are happy as editors. There are physicians who are happy as bankers. We know an engineer who is happy as a safety and personnel supervisor. The require-

ment seems not to be that it is the congenial job of our first choice, but rather that it be a job that gives an opportunity to do something, to show results.

Purposely, we place the next requirement second instead of first: It must be a job that offers us a living, sufficient for our needs and for our desire to grow. Of course, we place this first in daily practice. But the job on which we are to keep happy must be one that we can feel is worth while. If you will count the men and women you know who are happy on the job, will it not be a list including many who could earn or receive more pay in another job if they chose? We all can think of business establishments that pay the highest wages in their communities, with nobody happy on the job. However, first or second, it must be a job that supports us according to our needs.

Is it enough that it be worth while in our own eyes, and paid well enough to meet our needs? Is not one of the great handicaps to happiness on the job the fear of insecurity?

This fear in its present form is new—almost new in our generation. The new organization of industry has made each of us dependent on some one else for the permanence of his job. This is an added insecurity, different from the old fear of poverty in old age. The dependence is complicated by the fact that each of us, during his active years, long before old age, is dependent upon the wishes and ability, not of one employer or one industry, but of untold millions of customers. We can no longer feel the assurance once embodied in the words "a little land and a living surely."

The automobile worker cannot keep happy on his job if a hundred thousand people who were expected to buy the car he helps to make do not or cannot buy new cars. The building tradesman, who may feel that his job is the most soundly productive in the world, and that his wage rates are ample for his needs, still cannot be happy on the job when the out-of-work automobile mechanic cannot buy the house he should be building.

The job on which we are to keep happy must be one worth while, it must provide us a sufficient living, it must promise reasonable security. What else? A world of simple things, some unimportant in themselves, but infinitely important as

signs of the presence or absence of something basic in our working relations.

The job must give us working conditions that are not unfavorable—conditions of safety for health and limb, conditions that do not offend our sense of order, of cleanliness, of comfort. For most of us, it must be a job that is not the treadmill of perpetual routine, but that will permit our minds to grow, our hands to take on added skill, our judgment to mature. It must be on an open road to growth.

Perhaps more than all these requirements of conditions, it must be a job in which we can help to set the conditions. For most of us, the chance to have this voice in working out our happiness is more fundamental than any other single need.

These are things we all demand if we are to be happy on the job—satisfying work, a sufficient living, a sense of security, physical safety and comfort, a chance to grow, and a voice in forming and guiding the conditions of the job. A recent address by the president of one of America's great manufacturing companies includes a paragraph which gave me so much satisfaction that I am quoting it as the central thought of our discussion to-night. Speaking on the subject "A Basis for Employee Relations" from the standpoint of a very large employer, he said: "The best that I can do to describe our methods is to define the principle upon which they are based. Those of us in our organization who have employee relations as a responsibility are in pretty thorough agreement on a basic point. We feel that there is no such thing as human happiness without self-respect."

The speaker goes on to point out that this self-respect is achieved in different ways by different individuals—some by having mastered a craft, some by material success, some merely by having lived according to precept. But in every case there is needed the sense of personality, the sense of being an individual.

Can we not all accept this one element as fundamental to happiness on the job? To repeat the quotation, "There is no such thing as human happiness without self-respect."

If we can accept this fundamental, perhaps our problem is easier. The things we have mentioned as essential to

happiness are comprehended in the picture of self-respect—worth-while work, an adequate living, security, safety, comfort, progress, and self-expression. Using the fundamental of self-respect as our measure and test, we can identify those handicaps to happiness which must be removed, those supports to happiness which must be provided, those mental and spiritual adjustments which must be made.

Some forms of restriction are fatal to our self-respect and must be removed if they are now imposed on us. In a modern world we cannot have absolute independence, but we must have a degree of liberty.

For me or you, on the job, to be forbidden to join an organization of our choice, for the betterment of our group, is a restriction of this liberty, an obstacle to self-respect. Since this right is now guaranteed by law to workers on the job, we need not discuss our acceptance of it. But it fits our topic to look beyond the law, and to realize how fundamental is this right of an employee to join such an organization of his own choosing. The denial of this right has persisted to our day and has been a basic restriction upon the self-respect of the individual worker.

To be compelled to join an organization not of his own choosing is an equal attack on the self-respect of the worker on the job. May I emphasize that we are talking about the worker *on the job*. To the prospective worker, the applicant for the job, many conditions may be proposed, which he may accept or reject by his own free choice. He may even agree to a condition objectionable in itself, if his need or desire for the job outweighs his objection. The essential thing is that he makes the choice.

Having joined an organization of his own choosing, the worker cannot retain his self-respect if he is denied a voice in the government of the organization he has joined.

The worker cannot retain his self-respect if he is compelled permanently to live under conditions below the standard of adequacy; if he is compelled to work under conditions below a proper standard of safety, health, and comfort; if he is submerged in a mass where his individuality is ignored, either in the shop or at the Union Hall.

Self-respect is impossible in an atmosphere of disrespect.

Being subjected to the abuse, contempt, or arbitrary caprice of a so-called superior will throttle the self-respect of even the most aggressive man on the job.

This next question we often overlook. Grant that we cannot achieve self-respect in an atmosphere of disrespect from our so-called superiors, can the so-called superior achieve self-respect if we display an attitude of disrespect toward him? In other words, are foremen also people like the rest of us, who have a right to be happy on the job? Can we attain our own self-respect without extending decent respect to those who plan and supervise our work? If the foreman is not possessed of a character worthy of the respect of his fellow workers, he cannot be qualified for his position of responsibility. Unless we can give respect and loyalty to those who direct our work, they cannot retain their own self-respect. Lacking that, they cannot give us in turn the conditions that permit us the self-respect we need.

Self-respect is impossible where the opportunity to grow is denied us. In a set of conditions under which we feel that we cannot progress on the basis of skill and merit and ability, we cease to respect ourselves and lose the foundation of happiness on the job. It makes no difference whether the condition is created by ignorance, unfairness, or favoritism, or by the boss, the law, or the union. We need to have our individuality recognized, our personal growth permitted, our personality respected.

Finally, self-respect demands that certain barriers to self-expression be removed. If we are denied the right to influence the conditions on the job, we shall have neither self-respect nor happiness on the job. It does not matter whether we desire to express ourselves personally or through a representative or a union of our own choosing, we have a right to be heard.

We cannot expect to accomplish all the changes we may want in our working conditions. We must recognize the fact that other workers, the foreman, the employer, the customer, have the same right to be heard. But respecting their right, realizing that all things are not possible to us, we still are able to achieve self-respect only under conditions in which our right to speak is respected.

These, then, are the external handicaps to self-respect and happiness on the job that need to be cleared away wherever they exist—inadequate pay, insecurity, low standards of health and safety, arbitrary bars to advancement, denial of the right to self-expression.

What external assistance must we seek? Very little, I hope. In a material way, the basic progress of American industry brings us an ever longer list of *things* as aids to our happiness. Perhaps in a small area of our lives on the job we must seek the external aid of government. But in a government of the people, we have learned that laws ahead of their times are useless. Our thinking must be ready for them or the laws will not work.

Because in the mass we are ready for them, we have obtained the external assistance of government in certain positive ways which add to our happiness on the job. Most of us have seen the emergence of workmen's compensation and safety laws, laws limiting the hours of women workers, and more recently the broad group of social-security laws.

The adequate living that our jobs must give us requires some external assistance that it may be more than a living—if you will permit the phrase, that it may become the more abundant life. We need the external assistance of community action which enriches our lives with schools, and libraries, and roads and parks, with provisions for community health and sanitation and recreation.

Finally, what internal understandings and adjustments are needed in our thinking? Perhaps, in the presence of members of the Mental Hygiene Society, I should suggest no answer. Perhaps, in the presence of students of psychology and philosophy, I should have placed this question first. Certainly many of you will have better answers. These are my suggestions.

As employers, we must rid ourselves of every trace of paternalism, of what our friend has called the Jehovah complex. This must go because it invades the sacred personality of the other man and seeks to substitute dependency for self-respect.

As workers, we must rid ourselves of the desire to dictate—

the "or else" psychology, with its rough-shod disrespect for the rights and needs of others.

As students and scientists, we must avoid the desire to impose a plan of happiness by the edicts of logic and science.

As citizen politicians, as ambitious leaders and organizers, we must reject the temptation to exploit a condition that makes for unhappiness. Where we see a barrier to happiness for which we have a solvent, the attack on the condition of wrong or injustice must be a cause in itself, not a pretext for the promotion of personal or partisan ambitions.

We must school our individual minds to answer the question of what it takes to keep happy on the job, not for the group or mass, but for each of us as an individual. Our Western minds cannot be reshaped to the Oriental concept that happiness is in the elimination of all desires. To us it lies in hope of the satisfaction of desires. Therefore, we must face the need of having desires, of identifying them, weighing their worthiness, pursuing them. We cannot reach the goal until we have a goal to reach.

We must adjust ourselves to the abandonment of any pursuit of happiness at the cost of the happiness of others, to any achievement of self-respect at the cost of the self-respect of our fellow men.

The greatest agitator for keeping happy on the job gave us infinite wisdom in few words. He told us of the more abundant life. He urged the sacredness of personality. He demonstrated the need of growth in body and in mind. He exemplified the dignity of occupation and the self-respect that goes with a chosen field of work.

Beyond our task of removing external barriers and enlisting external aids to happiness on the job, he taught us that the Kingdom is within, but that we cannot confine it there while we pray that it may come; that we are not our brothers' keepers, but that our brothers are entitled to tolerance and respect as persons like ourselves, who like ourselves have the Kingdom within.

AN EXPERIMENT IN CHARACTER BUILDING

HELEN ALDEN KLEIN
Los Angeles, California

GREAT strides have been made in understanding the problems of and caring for the needs of dependent, delinquent, and defective children. So-called problem children in school also have received attention. But the everyday run-of-the-mill child has been passed by because he or she has not been sufficiently disturbing to attract the spotlight of social case-work techniques. Nevertheless, social case-work has much that is useful to contribute to the teacher and the group worker in furthering the normal development of every child.

A five-year experiment recently conducted by the All Nations Foundation in Los Angeles proved conclusively that the individual approach to group field work makes character building a more predictable technique, and that an understanding of each child in the group—a consideration of his personality traits and problems—not only results in a more constructive group program, but also makes it possible to help each child to develop his interests and abilities to the greatest capacity. This project, however, was demonstrated with a group of underprivileged children on a clinic basis. A case conference determined the needs of the child as shown by physical examinations, intelligence tests, family history, and social and emotional history as revealed by parents, teachers, and club leaders. Treatment was planned to meet these needs, responsibility being taken by group leaders or social workers, depending upon which could most effectively carry out recommendations.

A recent attempt has been made to try out this concept of "individual approach" with a group of so-called "privileged children," a group that is probably superior mentally and physically to a cross section taken from the public schools of the city and that has supposedly been subjected to a more wholesome environment as well. It is, therefore, a group in direct contrast to the group served by the All Nations experi-

ment. The method, moreover, has been a less intensive one, partly because of the nature of the group (a class in the church school of the First Congregational Church of Los Angeles) and partly because the work was undertaken on a volunteer basis, although by a trained and experienced social worker. It was felt that this church setting was an admirable one for an experiment in character building of this kind. First of all, this church-school program aims to contribute to the development of childhood toward maturity in the fourfold aspect of mental, physical, social, and emotional growth. It is interested, accordingly, in understanding the individual child, in helping him to overcome his difficulties and to use his interests and abilities to maximum advantage for himself and for his group.

Its teachers are for the most part persons with public-school experience with children of the same age level as those that they are teaching in the church school. There is constant attention to the improvement of the teaching program, the outlook being definitely a progressive one. There is, for instance, emphasis upon the principle that the child should be taught only those religious concepts that need not be unlearned in later life. Stress is placed upon the interpretation of these concepts in terms of social living rather than upon the concepts themselves. Furthermore, this church offers many facilities for development. The Sunday program provides for handwork, chorus singing, and gymnasium work in church and lesson periods. A children's church, under the direction of the wife of the minister, is conducted prior to the church-school program. The children hold office and take responsibility, participating in their own church in the same way as do their parents in the adult-church program. The children are very enthusiastic about this feature of the program. There are also weekday activities in the form of dancing, dramatics, Camp Fire for the girls, and Friendly Indians for the boys, all under trained leadership.

A mothers' council which functions actively meets once a month. Teachers and mothers discuss character education in terms of religious training and listen to speakers who are concerned with the mental-hygiene approach. Most of the mothers and many of the teachers are members of Parent-

Teacher groups and bring to the mothers' council the enthusiasm that they have developed in their public-school activities.

The project was limited to the A3 grade because the time element necessitated starting with only a small group, and also because the children in this class would move on to another department at the close of the semester, thus extending the service to two departments.

The experiment has been under way six months. During that time twelve children have been studied, seven boys and five girls. The procedure for obtaining material to be used in the attempted development of the child was as follows: First the parents' coöperation was solicited and a call made in the home, where the parent (usually the mother) discussed with the visitor the child's abilities, interests, and behavior traits. Second, in a controlled interview the child was encouraged to talk about his playground equipment, his playmates, his interests and his attitudes toward them. Finally, the significant findings from these two interviews were brought to the supervisor of the department and the teacher, whose already acquired knowledge of the child as seen in the group, together with this new information regarding the child as an individual, enabled them to plan a constructive program for each child. Matters of general implication were used by the supervisor as opportunity arose. The director of religious education was also in close contact with the work and discussed any problems that became apparent.

The study brought out certain facts about the group as a whole against which the findings regarding each individual child could be placed in comparison. For instance, the ages ranged from eight to eleven, the average for the girls being eight years and that of the boys nine. These twelve boys and girls had thirteen brothers and sisters who were attending church school. Approximately seven parents and six grandparents were members of the church, while ten parents were not members and did not attend. The mothers of all the girls were members of the Parent-Teacher Association and two mothers of boys were also members.

Although all but one of the children were in the same grade in public school as in the church school—the A3 grade—they varied greatly in reading achievement. Two were below

grade while at least three were able to read on fourth- or fifth-grade level.

Interests were determined in each case. Drawing appeared to be the most popular and attending movies one of the least indulged in. Special interests and abilities in music were discovered as well as the relative proficiencies therein. Two of the boys showed real ability to construct from wood and a third boy made model airplanes. A lack of interest in dolls was very noticeable on the part of the girls. As one little girl said, "I consider dolls babyish." All, however, enjoyed outdoor games, particularly roller skates. Two of the girls were particularly fond of climbing trees. Two boys and one girl did not like sports, undoubtedly because they were not proficient in that respect. Most of the children were interested in pets and in more than half the homes there were pets, usually a dog.

From a physical standpoint, three girls and two boys were underweight, one boy and one girl were overweight, while the rest were about average for their age and height. Most of the children were found to have good eating habits. Only two had anything approximating food fads and these did not seem serious. Two or three were inclined to overeat or not to eat enough. According to the parents, most of the children slept well and woke without being called. Two or three of the children found it hard to relax and go to sleep, however. Four boys and two girls had home responsibilities. Two of these boys earned money by selling newspapers and magazines and had allowances, one saving to buy his own clothes. Several of the other children also had allowances which some saved and others spent. In all cases there was an effort on the part of the parents to teach the children how to use their money.

The children all seemed to like the church school, although previously there had been one or two unhappy and unwilling to attend for reasons which had been cleared up in one way or another at the time of the study. Those living in the vicinity of the church usually engaged in some weekday activities. Others had club activities elsewhere. The girls, particularly, seemed to be very busy, having activities or lessons scheduled several days in the week. Their calendars seemed as crowded as those of adults.

Many different personality traits were evident in the group. Most of the children in the group displayed in diverse ways evidences of sensitiveness. Most of the children were definitely social and at least ten of them got along with adults, as observed by parents and the church-school teacher. All the parents felt that their children were obedient, and the majority were considered even-tempered and affectionate. Some did not like to display affection, others were impulsive, and at least half the group craved attention to a marked degree. Most of the children could take responsibility and liked to, and five could be considered self-assured in most situations. Three seemed to have analytical powers highly developed for their age. Three were shy. Certain attitudes of intolerance, race prejudice, supersensitiveness, relationships with others, and so forth became apparent.

Thus it can be seen that the study provided a birds-eye picture of the group as a whole and of each individual's relation to it. It was possible, with such information available, to plan a program around the needs of the group, whether attitudes that needed to be changed or developed or handicaps in individuals that became less destructive when understood by the teacher and handled intelligently. Interests were stimulated and encouraged. The teacher said, "I feel so much closer to my children since I understand them better, and I know that the programs I plan are much more successful when I plan them with each child's needs in mind." Another advantage of this procedure has been that the mothers are drawn into the general plan and are able to participate in the program through their active coöperation with the visitor. By this means they are led to closer contact with the teacher and to a better understanding of her aims.

From the standpoint of the individual child, several problems of unadjustment were brought to light. Some could be remedied through facilities at the disposal of the church school; others needed long-time treatment opportunities with parents. The latter method it was thought best not to employ at present. However, more intensive treatment may possibly be underaken when an educational process has made the parents receptive and when or if a full-time staff member, trained as a psychiatric social worker, is available. In the

meantime, knowledge that problems do exist is an advantage and there are many opportunities for the visitor or the teacher to do or say the constructive thing at the right time. The following case story serves as an example of how individual problems have been handled.

Ben was an eight-year-old boy, taller and weighing much more than the other boys in the group. He was awkward physically; in fact, he seldom joined with the other boys in their play. His feelings were easily hurt, and he went to the teacher for protection from the teasing of the other children, who called him "Fatty." He often did little things to distract the children when the teacher was trying to hold the attention of the group, and so was very annoying at times. His family were well-to-do people with some social status which they appeared to prize highly. An older brother was very successful in school and in athletics as well, his achievements making him the pride of his family. Ben looked up to his brother, who was six years his senior, but received little attention in return. In fact, he was rather ignored. There were few companions of his own age in the neighborhood, so Ben was left to amuse himself, which he did much of the time by drawing. He drew by the hour—very well, too, for a boy of his age. In school he was up to grade and read quite well aloud. This he was encouraged to do at home. He did not like school and was reported not to get along well with the other children. His mother, although somewhat concerned over the reports from school, was not disturbed apparently by the lack of companionship for Ben in the neighborhood, as she was very particular as to the children he played with and preferred none at all to the "wrong" ones. Ben was extremely generous with other children when he did entertain any in his home, often giving them some of his toys.

At the age of five, Ben had been very ill with scarlet fever, had had a long convalescence, and consequently had received a good deal of attention, particularly from his mother. He had been diagnosed by a children's specialist as an endocrine case, but thyroid treatment had had to be discontinued temporarily because it overexcited him. As a result he was often tired after a relatively small amount of exercise. He never played ball. His mother thought he did not like it or any

other form of physical activity. This did not worry her; she merely accepted it as a part of Ben's personality, and it had no implications for her. Ben enjoyed being around with his father when he was at work in the garden, which was just being developed, as the family home had only recently been built. The father treated Ben as a pal, and Ben in turn adored him and was very affectionate with him.

Another fact learned was that Ben was left-handed, although the family were very careful not to call attention to his occasional awkwardness. In an interview, Ben responded in a very adult manner, seeming to enjoy himself, but getting restless toward the end. He displayed a superior attitude toward the children of his neighborhood, apparently undisturbed that he had so few friends.

As the situation unfolded during the interviews with the mother and Ben, and in the light of the teacher's description, it was obvious that this child had first of all a physical handicap about which nothing could be done at the time, although it might be alleviated in the future. Not only did this handicap make it unpleasant for him to engage in physical activities, but the nickname given him by the children was a constant threat to his self-respect and never allowed him to forget for one moment that he was handicapped. Furthermore, his environment was such that he had too few companions of his own age. His brother, whom he admired, found him a "nuisance" and barely tolerated him, all of which threw him back upon the companionship of his father. This relationship, which in a lesser degree would have been a fine one, was too exaggerated to be entirely healthy. There still remained some of his infantile attachment to his mother as well.

What could be done by the church-school set-up in this situation? The visitor, during the interview with the mother, pointed out the dangers that might result from the boy's dearth of companionship. When the mother spoke of Ben's close relationship with her and with his father, showing some concern for its marked intensity, the visitor discussed the problem with her, helping her to face the situation without becoming emotionally disturbed. That is, the visitor's objective attitude seemed to relieve the mother's concern at this point. On the other hand, one or two suggestions were made

as opportunity arose during the conversation—for instance, that the brother be encouraged to give a little attention to Ben, allowing him to hang around when a game was going on instead of sending him home with an impatient word. It was also suggested that Ben be given lessons in one sport that he could learn to do well, swimming possibly, and that he get into some weekday group where he might gradually become assimilated. Some of these suggestions the visitor felt were accepted by the mother, others were rejected. A longer time with more contacts might have achieved more, but such a procedure did not seem feasible under the present plan. At least the mother was able for the first time to visualize what problems her child was facing and was given some definite suggestions for coping with them. In this way she felt that the contact with the visitor was worth while and that the way was paved for future contacts should she feel a need to discuss these problems further.

From the church-school angle, several points were discussed with the teacher, who was interested and tried to carry them out as time and opportunity permitted. Having some inkling as to why the boy was behaving as he was, she had more patience with his compensatory behavior and was less annoyed by him. She gave him opportunity to draw a poster to display in connection with a lesson before the group, thus giving him some of the status that he badly needed. She talked to the class one Sunday when he was absent and encouraged them to give him a different nickname, attempting to stimulate a kindly and thoughtful attitude in the group as well as making the situation a happier one for Ben. She encouraged Ben to join the manual-training group held during the week and was pleased to note that he had begun attendance. She then talked with the instructor, explaining Ben's left-handedness and his sensitiveness regarding it. The instructor's interest was aroused, and in consequence he encouraged the boy and saw to it that Ben learned to complete each step by himself and to find joy in his accomplishment. The teacher made sure that Ben got his turn to read before the group and found that, with this increased attention from the group, he abandoned some of his annoying ways of getting attention. Also, although there was room for improvement, he was, before the

end of the semester, becoming more accepted and more at home in the group. All of this information was to be passed on to the next teacher, so that her treatment of the boy would be consistent with that of his previous teacher.

For another year certain plans are in process of formulation. The visitor expects to study the entire incoming A3 group during the first semester. Any time remaining will be spent in completing the studies of those in the former group for which there was no time in the spring. Thus the same type of work will be continued. In addition it is hoped that a form of group recording may be started in one of the groups under study so that a week-by-week picture of the activities, relationships, and attitudes displayed by the children in the group will be available. A course in the understanding of the behavior of children from the mental-hygiene and sociological standpoints as a part of the teacher-training program is greatly needed and would facilitate the carrying out of the program as outlined. Eventually, as previously indicated, it is hoped that the work will be under the leadership of a trained member of the staff who will have full time to devote to the "individual approach."

It is interesting to evaluate this program as related to other forms of social work. It probably resembles the visiting-teacher program as closely as any phase of social work. There are certain points of departure, however. While it has status as a part of the church-school program, just as the visiting teacher is a part of the public-school program, it is not recognized as a separate unit and does not exist in the minds of the parents except as integrated with functions of the church school. It is not associated in their thinking with the social-work field. They can accept it enthusiastically *per se,* but would be antagonized by the connotation of social work. Another point of difference is that it is recognized as a developmental service related to the problems of children, but giving the same consideration to each child, regardless of the seriousness of the problems. In other words, a child is not studied because he or she is a "problem child" or even because problems are developing, but merely by virtue of membership in a certain group. A third point is that the parent is drawn into the church-school set-up as a coöperating participant and does

not remain an outsider. As a matter of fact, the parent is consulted rather than interviewed.

The technical approach has to do partly with the manipulation of the environment for the benefit of the child's development and partly with the establishment of relationships with parent, teacher, and child. These relationships provide opportunities for the release of emotional tensions and for the gradual change of points of view. The mother finds a sympathetic, but objective listener in the visitor whose case-work skills can be helpful in assisting the mother to straight thinking regarding her child's problems and her own attitude toward them. Release of emotions often clears the air and puts the mother in a receptive mood that permits her to accept new ideas. Constant stress upon the importance of the need she is filling in contributing to an understanding of her child gives the mother confidence in her position as a parent and thus adds to her feeling of security.

The teacher also develops greater awareness of her problems. While she does not feel the emotional ties to the child that the mother feels, she often develops strong likes and dislikes, even aversions. When these are expressed and discussed with the visitor, especially in the light of the information brought from the home, they seem to be better understood by the teacher, who learns to treat each child with equal consideration and with far greater insight. The teacher, moreover, feels much more confidence in the effectiveness of a program that she tries to build around the needs of the individual children.

The interviews with the children were used to gain their confidence and to observe them in the informal question-answer situation. The children seemed to enjoy the experience and asked for their chances ahead of time. The benefit to them from an emotional standpoint comes partly through changed attitudes on the part of parents or teachers. It has not been possible so early in the experiment to measure the values resulting from contacts with the visitor, although there are evidences to indicate that here also relationships play a constructive part.

The type of interview used with both parents and children might be termed a form of short-contact interview. Both

were necessarily controlled to a large degree because in each instance certain specific information was sought. Every effort was made, however, to get the parent or child being interviewed to accept a coöperative rôle, to feel a responsibility as a participant in relation to the plan as a whole, and to derive satisfaction from such participation. Although the way was paved for further contacts if they should seem necessary and advisable, the visitor endeavored to leave the person interviewed with a feeling that something worth while had been completed and accomplished in this single interview.

Such an experiment as has been described is distinguished then by three factors: (1) the study of individual children of superior ability and background on the basis of membership in a particular group; (2) the use of a church-school group with character building its distinct aim; (3) the use of social-case-work techniques in short-contact situations, treatment being partly manipulation of the environment and partly the release of tensions and the direction of attitudes through the use of relationships. The project is in its infancy, yet it appears to have definite possibilities from the standpoint of character building. Although there are weaknesses, it seems possible that many of them can be eliminated as time goes on. Certainly the results so far seem to justify the continuance of the project.

BOOK REVIEWS

MENTAL HEALTH THROUGH EDUCATION. By W. Carson Ryan. New York: The Commonwealth Fund, 1938. 315 p.

What is education? He who wonders about this question will be interested in the point of view that runs through Carson Ryan's *Mental Health through Education.* Certainly he will conclude that modern education is much more than the "inculcation of knowledge" or the "preservation of culture." For Mr. Ryan has little to say about these things and much to say of happy children and sympathetic teachers. He visited nursery schools, adjustment classes, private and public elementary and secondary schools; he studied college-catalogue descriptions of courses, interviewed teacher-training instructors, and "sat in" on their classes. The resulting portrayal of American education, while faintly reminiscent of grandmother's patchwork quilt, is vivid and thought-provoking. The attention focused upon the discrepancy between accepted mental-hygiene principles and current practice, while not unfamiliar to the thoughtful educator, demands consideration. Mr. Ryan's illustrations of effective mental-hygiene procedures (many would say sound educational principles), observed or read about from nursery school to college, give the reader a yardstick by which to evaluate known practices.

Mr. Ryan finds that many of the usual school procedures violate "accepted principles of mental hygiene." His criticism of such procedures is caustic and in many cases deserved. It would be helpful to have the "principles of mental hygiene" clearly defined somewhere in the book. The reader is left to assume that these principles are good, but is never told just what they are. He must often derive meanings from negative statements. For example, Mr. Ryan says definitely that "grades, promotions, recitations, home work, examinations, and discipline" are "serious obstacles to mental health and sound education." Are we to assume that children are injured by being compelled to meet obstacles and to attain definite standards? Are psychiatrists convinced that, if it weren't for interference by teachers, children would educate themselves and develop latent creative power that is now crushed? One almost gets the impression that the teacher is the enemy of the child.

Mr. Ryan is rightly critical of the provisions for educating teachers for the modern school. Certainly a country as rich as America should be ashamed of the low standards that have prevailed in the teaching profession. It is not clear, however, that he has sufficient evidence for saying, in connection with the problem of selecting

applicants for entrance to teacher-preparation institutions, that "probably admission on a scholastic basis is worse than indiscriminate admission . . . since there is no direct connection between scholarship and good teaching." It is too easy to generalize from one or two instances of scholarly persons who have personality difficulties that scholarship is not a necessary asset in a teacher. One can admit that not all scholars will make good teachers and yet know that in a large majority of cases teachers have little success in trying to teach what they don't know. Let us add understanding of individual needs and of emotional difficulties to adequate scholarship instead of starting with a poor foundation of intellectual ability. Mediocrity of intelligence does not seem to be a necessity for the development of a wholesome personality.

In evaluating the efforts of teachers colleges to advance the cause of mental hygiene, Mr. Ryan seems to fall into an error similar to that for which he criticizes the ordinary school. He believes in "activity" rather than in scholastic learning, yet he lists the contributions of teachers colleges by the courses in mental hygiene that they give rather than by the complete program that they have developed in the institution. He says that "such courses may have little or nothing to do with what really counts—the life of the school," but apparently he found no college that lays stress on the *life* rather than on the *courses*. If such a college exists, it would be interesting to know what success it has had and how this was achieved.

Education in modern America has assumed the tremendous task of taking care of all children beyond a certain age and in types of activity never before assigned to the school. In meeting this task, some old concepts will have to be discarded and others modified. Teachers need a far deeper understanding of boys and girls than they have ever had if schools are to fit for living that is wholesome to the individual and to society. In turning attention to the central problem of education, the child, ***Mental Health through Education*** gives added impetus to the movement for a comprehensive, dynamic school program.

ROSCOE L. WEST.

State Teachers College, Trenton, New Jersey.

SEX, CUSTOM AND PSYCHOPATHOLOGY: A STUDY OF SOUTH AFRICAN PAGAN NATIVES. By J. F. Laubscher. New York: Robert M. McBride and Company, 1938. 347 p.

Information on the comparative behavior and the psychopathology of various types of peoples and racial stocks is always welcomed by those who have devoted their energies to the study of mental disorders. This unique book has been prepared by an observer who, by virtue of training and experience, is qualified to study and to evalu-

ate the phenomena in this selected field. The author undertook an ethnological and psychiatric investigation of the Southeastern Cape Bantus, a group available because of its proximity to the Queenstown Mental Hospital. The native patients in the hospital wards, the natives in the community, the chiefs of kraals, the elders and councilors, the tribal chiefs and headmen, the magistrates and the commissioners in the territories were utilized as sources of information. The data thus obtained, together with personal contacts and observations, have been arranged and presented in fifteen chapters. The titles of some of these sections—namely, *Folklore, Sacrifices and Customs Associated with Birth, Childhood, and Adolescence; Pagan Rites and Burials, Initiation Ceremonies; Native Concepts of Mental Disorder; Sexual Offenses;* and *Mental Hospital Material*—indicate the nature and range of the subject matter.

A number of interesting features are found in the behavior patterns and customs of the Tembu peoples, and the author has utilized psychoanalytic concepts to explain a great deal of his data. Some valuable information is given on the sex life of the Tembu, particularly on the courtship proceedings and on *metsha,* which is a form of overt pseudo-sexual intercourse. There are psychoanalytic interpretations of witchcraft and of other beliefs. The customs and beliefs connected with witchcraft are formed out of the nature of the environment and largely determine the native's conception of mental disorders; in fact, "the pagan native schizophrenic patient in his regression keeps, on the whole, within the fold of his cultural belief, expressed as ideas, because the archaic and magical forms of thought are as much part of his normal state as they are of his psychiatric state." The native's cultural pattern determines the nature of his mental content, but the basic structure of a psychosis is similar to that seen in European culture. Analyzed dream material is not presented, but the behavior of the individual and the mental content are utilized for purposes of interpretation; for example, the spirits called the "River People" figure in the daily lives of the natives and often appear prominently in the anamneses of schizophrenics. These spirits are regarded by the author as symbols of the super-ego. On the whole, the cultural status of these people is "phylogenetically on a par with the Œdipus-complex phase in ontogenetic development."

The present-day tendency to consider psychopathological phenomena as due largely to environmental influences and practically to exclude constitutional and other biological factors is pointed out by the author, whose findings indicate the importance of a number of somatic components. His studies of schizophrenia in these pagan natives as well as in Europeans, Cape colored, and Malays have convinced him that not only is the organic background the essential

factor in the disorder, but also that the capacity of the patient to respond to treatment depends upon the degree of malignancy of the organic determinants.

The prevalence of schizophrenia among the tribes studied by Laubscher is indicated by the number of admissions to the institution. Among the male patients admitted, 54.5 per cent, and among the females, 67 per cent, were schizophrenics, conforming to the classical paranoid, catatonic, and hebephrenic types. In contrast to these figures, the small number of manic-depressives is outstanding. Among the males, 6.7 per cent, among the females, 6 per cent of the admissions represented this psychosis. The Cape colored and native races rarely develop instances of manic-depressive disorder. Self-mutilation is rare among native patients, only two instances of attacks on the genitals having occurred during a period of several years, and suicide is so rare among the Bantu people that some magistrates have known of only three instances in the course of thirty years. Moreover, very few patients are sent to hospitals for suicidal gestures. This may be due to the absence of severe depressions and agitated depressive states among the natives. In contrast to a low suicide rate, the homicide rate is high in the Bantu native population, perhaps due to the pagan's tendency to externalize aggressive motives in an impulsive manner.

Europeans and others outside the native culture have the erroneous belief that the primitive native's general physical condition and situation are synonymous with his psychological state in terms of general well-being. The native's freedom in matters of clothing, in movement, his robust muscular development and emphasis on the physical needs of life are not indications of a freedom from mental conflict, however the expression of the conflict in terms of mental content differs according to the systems of belief and the cultural patterns and experiences. There are excellent descriptions of special hallucinations and delusions and traits of character that should be of great value to psychopathologists.

A short review is inadequate since one can no more than mention a few of the important subjects treated at length in this book, which should be of prime interest to psychiatrists, psychoanalysts, and ethnologists. It is to be hoped that others will be stimulated to make similar studies on the still existing "primitive" peoples before their cultural pattern is destroyed by "civilization."

The book includes a number of splendid photographs, illustrating a variety of cultural topics and mental disorders, and the material is indexed.

N. D. C. Lewis.

New York State Psychiatric Institute and Hospital.

COÖPERATION AND COMPETITION AMONG PRIMITIVE PEOPLES. Edited by Margaret Mead. New York: McGraw-Hill Book Company, 1937. 531 p.

What part does the social heritage play in shaping human personality?

The question has considerable importance. This was recognized some time ago by the Social Science Research Council, which set up a special committee on "Culture and Personality." In due course, several subcommittees were appointed to attack various aspects of the problem, and one of these subcommittees was that on "Competitive-Coöperative Habits." On this subject, it was felt, there was need for "a critical analysis of the state of knowledge, an outline of the existing frontiers, and a listing of immediately feasible small research problems to fill in the gaps and advance the frontiers."[1] One of the approaches explored was the anthropological, and this book, edited by Mead, gives the results of this exploration.

In *Coöperation and Competition Among Primitive Peoples* thirteen social systems are analyzed. In the case of each system, an attempt is made to determine whether the principal activities of the group are carried on competitively or coöperatively. Are the economic activity, the religious life, the family experience chiefly coöperative or competitive? On the basis of the principal emphasis in the culture, societies are then characterized as essentially coöperative or essentially competitive. In the interests of clarity these societies are arranged about the sides of a triangle, the center point of each side representing the most pronounced tendency. From this figure it is possible to tell what the investigators believe to be the major emphasis in any one of the cultures; also where a given culture stands in relation to the rest.

The base of the triangle is given over to the so-called "individualistic" peoples—that is, peoples who, according to the authors, function essentially as individuals and who can therefore hardly be said to be either coöperative or competitive.

To the reviewer this third classification, "individualistic," is confusing and sociologically unsound. If individuals function socially, they must either coöperate or compete, or do both. If they do neither, they scarcely constitute a social group, but are only isolated individuals carrying on independent careers. But this is not the case in those societies called individualistic by Mead. Thus the Ammassalik Eskimo are put in this class because, for

[1] See *Competition and Coöperation*, by Mark A. May and Leonard W. Doob, the report of the Subcommittee on Competitive Coöperative Habits. Social Science Research Council Bulletin No. 25, April, 1937.

instance, in hunting seals each hunter works alone. To be sure, the kayak is designed to hold only one person. But what should be emphasized here is that the food, although acquired by individualistic effort, is put into a common storehouse. In a word, the goal is coöperative even though the means of achieving it be individualistic.

When we speak of a coöperative society, we have reference to the goals, not the means. In a communist society such as Soviet Russia, for instance, the economic life is essentially coöperative, in that there is common ownership of the means of production. Yet recently the workers in various factories have been urged to vie with one another in increasing production. Here is competition used as a means of securing a coöperative result. The failure to distinguish between the goals for which a society strives and the means employed in attaining them constitutes a weakness in this study.

In addition to identifying the thirteen societies as coöperative or competitive, the study under review undertakes to answer two more fundamental questions: How shall the particular emphasis of a culture be accounted for, and how does the particular emphasis affect personality? In the concluding paragraphs of the book, Miss Mead gives an effective summary of her answers to these questions:

> "The most significant specific conclusions which can be drawn from the sample and used for further research are:
>
> "Strong ego development can occur in individualistic, competitive, or coöperative societies.
>
> "Whether a group has a minimum or a plentiful subsistence level is not directly relevant to the question of how coöperative or competitive in emphasis a culture will be.
>
> "The social conception of success and the structural framework into which individual success is fitted are more determinative than the state of technology or the plentifulness of food.
>
> "There is a correspondence between: a major emphasis upon competition, a social structure which depends upon the initiative of the individual, a valuation of property for individual ends, a single scale of success, and a strong development of ego.
>
> "There is a correspondence between: a major emphasis upon coöperation, a social structure which does not depend upon individual initiative or the exercise of power over persons, a faith in an ordered universe, weak emphasis upon rising in status, and a high degree of security for the individual."

These generalizations are supplied by Miss Mead in the concluding chapter, entitled *Interpretive Statement*. In addition Miss Mead supplies the Introduction, and descriptions of three of the societies. The other descriptions are contributed by Jeannette Mirsky, Ruth Landes, May Mandelbaum Edel, Irving Goldman, Buell Quain, and Bernard Miskin. These chapters make interesting reading and con-

stitute a valuable body of information about preliterate peoples, organized from a special point of view. There is also a short "Bibliography on the Problem of Culture and Personality" at the close of the book, and an index.

The book is a stimulating and original piece of work. Miss Mead herself disclaims any finality for her conclusions, but sets them forth only as incentives to further study and discussion.

M. F. NIMKOFF.

Bucknell University, Lewisburg, Pa.

THE ABOLITION OF POVERTY. By James Ford and Katherine Morrow Ford. New York: The Macmillan Company, 1937. 300 p.

Professor Ford of Harvard has for years made the study of poverty a major concern. Experience in social work, sociology, economics, and public affairs has enabled him and his collaborator to present a fair and dispassionate, but comprehensive, consideration of the various theories with regard to poverty, its causes, its prevention, and its cure. In this discussion of causes, the authors manage very successfully to draw distinctions between, on the one hand, pseudo-causal and precipitating circumstances, and on the other, fundamental conditions which actually predetermine ends that are disastrous for many people. The synthesis of data and points of view admirably distributes the balance between the psychological and the physical factors that underlie poverty. Interpretations are based on a sound recognition of the biology, as well as the sociology, of individual differences in ability to meet the demands of an increasingly complex world, whose problems challenge the combined coöperative insight and strength of the most intelligent and the most selfless.

This reviewer appreciates, in particular, the authors' frank recognition of the rôle of biological heredity as a producer of poverty. Man's endowment for potential development will determine his final adjustment no less than will his opportunities, not because poverty itself is inherited, but because, for all too many individuals, the biological equipment and ability to surmount it, is not. A wider grasp of birth-prevention measures by those who are to bear and rear the least capable offspring is an important step in the elimination of poverty. The Fords have kept up to date with a eugenics which has recently made itself more secure by restricting its interpretations and its activities to the factual data made available by the social sciences, and this only within the last decade or two. Indeed, it is doubtful whether the *Abolition of Poverty* could have been written a decade ago.

An understanding of the ultimate inevitability of the personal handicaps of vast numbers of our population, a knowledge of economic factors and their control, the ability to look facts squarely in the face, the adoption of sound policies for correcting the inherent evils that confront society at every turn, and a clear delineation of the problems that demand solution, coupled with a sincere sense of responsibility for the not-yet-experienced poverty of the future, could serve in enormous measure to reduce poverty, as America knows it to-day, to a "residuum of not-yet-preventable poverty."

An analysis of the functions of national economic planning may be stated in the authors' own summary (p. 163). Government needs to develop: "*first,* thoroughgoing policies for the conservation of natural resources so that coming generations will not be plunged into poverty by their exhaustion; *second,* policies to increase the volume of the nation's distributable wealth through the improvement at every point of the system of production; *third,* policies for the elimination of all needless wastes in the process of production; *fourth,* policies for the elimination of waste in the distribution of goods; *fifth,* policies for the elimination of waste in human effort through redistribution of labor and talents to positions where each can be applied most productively; *sixth,* policies for the redistribution of wealth in such a way as best to serve humanity; *seventh,* policies for the redistribution of income in such a way that an adequate minimum wage may be available for all laborers and their dependents; *eighth,* policies for the elimination of consumer exploitation, through the maintenance of reasonable standards of quality, safety, wholesomeness, and durability, for all products; *ninth,* policies that will encourage, stimulate, and foster experimentation, invention, and the general utilization of the findings of scientific research; *tenth,* policies to overcome unemployment occasioned by technological developments or by conditions of the market; *eleventh,* policies for unemployment insurance which will remove the threat of poverty from laborers whose incomes have been cut off because of changes in consumer demand, improvements in production, or for any other reason; *twelfth,* policies for the protection and development of wage-earner credit and thrift; *thirteenth,* policies for the fostering of sound wage-earner organization both for protection of labor from the aggression of employers and for the fulfillment of labor's economic and cultural interests in a manner consistent with the interests of the general public."

If our present system fails to find solutions for the thirteen problems outlined above, then a slowly-evolving state socialism, which will conserve existing principles of liberty and democracy, is the only answer to the abolition of poverty.

The book contains a chapter on the prevention of major disasters and another on the prevention of war, both characterized by the same sanity and intelligence that mark the whole volume. One reads one's way through a discussion of human misery, but emerges with an optimistic outlook. The task of abolishing poverty could be achieved, and within the framework of our present American democratic traditions. It's up to the people.

GLADYS C. SCHWESINGER.

American Museum of Natural History,
New York City.

PREVENTING CRIME; A SYMPOSIUM. Edited by Sheldon and Eleanor Glueck. New York: McGraw-Hill Book Company, 1936. 509 p.

This book consists of "own stories" from twenty-four agencies, representing various types or phases of crime prevention. From a long-range point of view, it is not necessary, in order to justify the book's title, to prove that the procedures described therein have prevented crimes in the 1930's. Crimes will be prevented more certainly if advantage is taken of existing knowledge and theory. The present authors admit that "the task is complex," involving all social institutions and continuous attack on all fronts.

The general principles of crime prevention laid down by the authors warrant repetition:

1. Crime-prevention programs should take into account the evidence that most criminals show definite antisocial tendencies of attitude and behavior early in childhood.
2. In most instances, children should be kept away from police stations, courts, and correctional institutions until more scientific and sympathetic efforts have failed.
3. An experimental attitude should govern the establishment and conduct of crime-prevention programs.
4. It cannot be definitely concluded as yet that any one type of crime-preventive activity is necessarily superior to, or should be exclusive of, any other.
5. Existing community agencies and institutions should be used to their fullest capacity.
6. While much good can be accomplished by whatever qualified agency in a community assumes the leadership in crime prevention, the public schools can play an especially significant rôle.
7. Although not indispensable, a crime-prevention bureau in a police department has certain unique values.
8. Crime-preventive efforts should be discriminating in technique.
9. A crime-prevention program should recognize that children must have ample outlets for their energies.
10. Other psychological and behavior traits of children should be taken into account in planning and carrying out crime-prevention programs.

11. Intensive work with problem children and delinquents and the attitudes and prejudices of parents should not be ignored.

12. Trained personnel should be liberally employed in crime-preventive activity.

To those well experienced in community organization, the "own stories" that make up this volume are provocative; grains of salt can be added in their proper places. For those less experienced, there is danger that the various presentations may encourage a tendency to choose this or that pattern, especially in view of the fact that many of the stories give only the favorable aspects of the programs they describe, avoiding any mention of problems to be solved in a self-critical spirit. Yet the authors of these stories are in a better position than any one else to point out such problems.

The stories are divided into six groups. The first, made up of four papers, deals with coördinating community programs:

The Los Angeles County Coördinating Council Plan describes a program that provides for the counseling of the welfare leaders in a neighborhood. It is designed to study, educate, and organize the various agencies in a neighborhood, and to bring to their attention those in need of their services. Kenyon J. Scudder, who contributes this story, might have improved it by "telling on" a few of his own delinquent progeny—those coördinating councils that try a hand at case-work, or those that tend to fall asleep on the job. In spite of these omissions, however, he is modest in his claim that the project has helped to make the community a better place in which to live.

In *The Lower West Side Crime Prevention Program, New York City,* Frederic M. Thrasher presents a modest, critical, scientific approach. It involves a great many diverse activities relating to the many causes of crime, and hence makes a less brilliant showing than some of the more intensively focused programs. Its very breadth is realistic, however, being postulated on small general gains rather than on narrow, concentrated results.

The Foundation for Youth in Columbus, Indiana, by Walter H. Hall and Robert K. Atkinson, discusses a program that is motivated not specifically toward crime prevention, but toward the satisfaction of the self-evident need of youth for opportunities to play. It has, consequently, no exaggerated promises to live up to. The efforts of this foundation, which are centered on a boys' club, are coördinated with all the other leisure-time services in the community through a joint director.

The Director-at-Large Plan of the San Francisco Recreation Commission outlines a plan for giving boys individual attention, getting them to the right agencies, providing them with constructive experiences, and supplying advice. The success of this plan obviously depends upon the selection of personnel for enthusiasm, critical technical service, and full-time application. Mr. Gerald J. Linares, the author of the paper, could undoubtedly have done better in pointing out the weaknesses of his program.

The next group of papers presents six school programs of importance in the prevention of delinquency:

In *Character Building for Crime Prevention in Public School # 181 in Brooklyn*, Dr. Nathan Peyser presents a plan based upon an educational approach so fundamental that the prevention of delinquency may be naturally expected to result. The schools have an opportunity, not only in their own sphere, but through their community relationships, to influence character development and to serve as centers of community morale. In this instance, the school became the nucleus of coördinated effort in the community. It undertook community surveys and organization to meet community defects. It had a paid professional staff, a case-adjustment service, a Big Brother phase, and projects in the field of recreation and of adult education. Dr. Peyser expressly states that it is all experimental.

***The Bureau of Special Service in the Jersey City Public Schools*, by Thomas W. Hopkins, is the account of another plan under which the schools have assumed leadership in community coördination as well as supplying special services—clinical, visiting-teacher, and the like. The point of view of the paper is clearly promotional; no problems are described, and there is some evidence of competitive feeling with regard to the coördinating-council procedure. One wonders whether in any community we have "the hearty coöperation of all existing private agencies."**

***The Visiting Teacher in the Cincinnati Public Schools*, by Ethel Reynolds, is a clear, dispassionate presentation with no exaggerated claims. Emphasis is laid upon the fact that the visiting teacher is in essence a case-worker, bringing into the educational system a flexibility that is beyond the range of the classroom teacher. In spite of this, the requirements for the visiting teacher are primarily educational and secondarily those of a case-worker.**

Dr. Henry J. Baker, in his paper, *The Diagnosis and Treatment of Maladjusted Children in the Detroit Public Schools*, recognizes the limitations and defects of his program and faces them squarely. This work in Detroit shows how much the link—in this case the schools—needs to be strengthened before it is forged into a chain of community agencies, and how one agency, by sawing its wood all the way through, brings about coördination of effort between agencies. It, again, shows how the prevention of delinquency may be approached as a by-product of a job well done in some one field.

The same point is brought out by Meta L. Anderson in *The Binet Schools of Newark*. Discussing the development of a high-grade educational program for the mentally retarded, this paper deals with some very personal reasons for the delinquency of such children. And again one sees how a program such as this, carried through on a high level, automatically brings about coöperation between community agencies. The presentation of the program is modest and critical.

***The Montefiore Special School for Problem Boys in Chicago* presents a plan that is more distinctly pointed toward the prevention of delinquency in that it is designed for truants. The Montefiore School combines the**

functions of a special school with some of the services of a child-guidance clinic. Its curriculum is specially adapted to the needs of its pupils, and in that respect it is a cross between the Newark program and the regular educational program, since most of its pupils are mentally handicapped. Here, too, we see how following through the needs of a special group brings about a natural coöperation between community agencies. Mr. Edward H. Stullken, who contributes the paper, is modest in his evaluation of the program.

Two accounts of police-department activities are given:

The Crime Prevention Bureau of the New York City Police Department, by Henrietta Additon, describes a program that has been discontinued. In its original form, it was distinctly a police program, dealing with minors in the early stages of delinquency and with such adverse community conditions as are within the reach of a police department. In addition, it exerted an unofficial influence for community betterment on the basis of the needs that came to its attention in the course of its work. Individual problems were dealt with by simple social-case-work procedures against a background of authority. Some of the bureau's activities were neglected functions of schools or other community departments. It was directed by a specially appointed police commissioner, assisted by a large corps of selected police officers and investigators.

In *The Crime Prevention Work of the Berkeley Police Department*, Elizabeth Lossing describes an evolutionary product with an attitude of critical self-appraisal and a detailed analysis of problems. The plan involved close working relationships with various community agencies, of which the first coördinating council was a natural outgrowth. High standards for its personnel have insured the progressive development of this program. The work includes service to delinquent adult women, to girls and young boys, and to children in danger of becoming delinquent; the education of lay and professional groups; and participation in community betterment and in "upstream work antedating prevention." A host of activities along this line include sports, reading, entertainments, and club work. In addition, the special bureaus within the police department, the personnel of the department as a whole, are expected to participate in crime-prevention work. The evaluation of this program is modest and no excessive claims are made.

Four intramural programs are presented:

Longview Farm, at Acton, Massachusetts, which is described by Leslie B. Blades as a study home for problem boys, accepts its clients chiefly from private agencies—boys who have social and personal maladjustments with which the ordinary foster home is not qualified to deal. The theory behind the work of the home is that "society itself produces problem children," and that the home must offer a more healthy social environment. While striving to be a typical home, it recognizes the fact that its authority is social rather than familial, but it avoids imposed study and treatment and gives the boy a chance to determine his own course, enjoying or suffering the consequences. Participation

in the work of the home, whatever its nature, is regarded as worthy of respect because of its social value. The experience is designed to be educative and to develop an appreciation of social responsibility, justice, and tolerance through the natural activities of every day.

The Children's Village at Dobbs Ferry, New York, described by George C. Minard, is another intramural project that is experimenting with the education of delinquent children. The Village has many advantages through its long experience and its proximity to the abundant resources of New York City. Its program is fundamentally designed to give the boys opportunity for natural self-expression, with the minimum of restrictions. The activities of the Village in the direction of the prevention of delinquency are rather implied than direct, on the principle that a satisfied consumer of our culture is its best customer.

The account, by Donald T. Urquhart, of the third intramural program—that of the George Junior Republic—while it is not promotional in the same sense as some of the other stories, expresses an almost overwhelming conviction. The Republic is an institution of the cottage type, designed like a village, with small groupings and divisions of labor. Training for citizenship is its paramount objective. It includes self-government and an economic program of earnings designed to teach the various values of property. An attempt is made to duplicate as far as possible the functions of a normal community and to force the boy to experience the results of his own idleness and antisocial conduct. As in the case of an established society, most of the needs of the community have been formulated in rules and laws within which individualization may take place. This particular account of the program deals much more with the regulations than with the individualization.

The fourth intramural program is that of the summer camp for delinquent boys at Greenwood Lake, Delaware, Ohio. It is described by Irving A. Wagner. The camp admits boys with behavior problems and problems of adjustment. It is not restricted to delinquents. It serves as an adjunct of the court through the appointment of its director to a court office. An attempt is made to provide such adequate supervision that the spontaneous interests of the boys will find natural outlets. Both counselors and boys are carefully selected. The success of the project is estimated with relative conservatism. Experience has led those engaged in it to feel the need of a continuation of the work through an inter-seasonal agency.

In addition to these four intramural projects, four extramural guidance programs are given:

Dr. Samuel W. Hartman contributes an account of the child-guidance clinic of Worcester, Massachusetts. This clinic was the gradual outgrowth of a state hospital's attempt to serve its community, although at the present time the community assumes a large part of its support. It serves all the community agencies, including the court, and thus comes into contact with the antecedents of delinquency. It selects those cases that are most in need of its peculiar contribution, which is psychiatric examination and treatment. Treatment consists of personal

direction of the delinquent or potential delinquent, directly by the clinic and through the court, probation staff, or home. Its program includes educational work, aimed at bringing about a better understanding of delinquency, and attacks upon community conditions that cause delinquency. Its staff is made up of psychiatrists, psychologists, and psychiatric social workers, all of whom take part in examination and treatment, their efforts being integrated through case conferences. The aim of treatment is to develop feelings of adequacy through a sense of "belongingness" and a philosophy of life. The clinic's attitude toward evaluation of its work places it among the more scientific and conservative projects.

The program of the Alfred Willson Children's Center, of Columbus, Ohio, is presented by Bertha Fulton. This project is a group effort which employs a psychologist, a social worker, and a physician. While it professes to be something "more than a child-guidance clinic," its staff really represents part of the usual child-guidance staff. It claims to carry on psychiatric work, but has no psychiatrist on its staff. Its understanding of the child-guidance clinic is obviously scant. It attempts child-placing, group work, parent education, and other activities usually carried on as specialized services, whereas its staff is confessedly not highly experienced.

The Big Sister Service in Rochester, New York, on which Elizabeth R. Mertz contributes a paper, carries on a quasi-professional case-work through volunteers under professional supervision and with professional assistance. Girls from ten to sixteen years old are referred to it by various community agencies for help with various types of personal-adjustment problem.

The Parents School of the Domestic Relations Court of Franklin County, Columbus, Ohio, is discussed by Erwin V. Mahaffy and Mabel L. Riebel. It is conducted by a select group of teachers who have been oriented in the various social fields, and its techniques have been developed experimentally. One of the conditions of probation for a child is that the parents shall attend this school, and everything is done to make it easy for parents to meet this requirement. The teaching is simple and to the point, in part didactic and in part carried on through group discussion.

The final section of the book deals with boys' clubs and recreational programs. Four are presented:

The All Nations Boys Club, in Los Angeles, discussed by Charles S. Thompson, has developed methods and techniques for leisure-time activities among underprivileged boys. Its work—a combination of group work and case-work—is carried on in the heart of a delinquency area. It provides a gymnasium, a library, craft work, clubs, games, and other social features, and conducts a summer camp. It has a small trained staff, which is supplemented by selected college students. It tends to estimate its value in terms of a decrease in delinquency rates in its territory.

The Boys' Club, of Worcester, Massachusetts, is designed to deal with the neglected boy. While it does not especially advertise service to delinquents, it does make a special effort to hold the interest of this type of boy. It carries on the usual functions of a boys' club, offering a variety of facilities and supervision. It recognizes that its work is a part of a community prevention program, and its claims, as presented by David W. Armstrong, are modest.

Harold S. Keltner outlines the crime-prevention program of the Y.M.C.A. in St. Louis. This is a project for guiding into constructive activities the naturally organized gangs found in less privileged neighborhoods. Many minor deviations of behavior in these gangs are accepted in the effort to divert them from more markedly antisocial activities. Leadership is provided, but in the main the clubs depend upon their own resources rather than upon outside charity.

The program of the Philadelphia Boys' Club and Settlement Project is presented by Robert C. Taber. This project grew out of an effort to direct quasi-delinquent boys to community resources that might be of value to them. This proved to be such a large order for the one person employed that it was made a special project under a federal program, using untrained personnel. An essential part of the program has been the training and supervision of these workers. Evaluation of this program on a quite objective and critically conceived plan shows significant results.

While there are obviously great differences in the evaluations of these programs as well as in the approaches to the prevention of delinquency that they represent, they provide a useful guide for any community group that is instituting work in this field. Seldom will it be possible to copy any of the programs in its entirety, but all of them are suggestive and offer valuable leads in the organization of a program adapted to a particular community.

GEORGE S. STEVENSON.

The National Committee for Mental Hygiene.

LATER CRIMINAL CAREERS. By Sheldon and Eleanor Glueck. New York: The Commonwealth Fund, 1937. 403 p.

In 1930 Drs. Sheldon and Eleanor Glueck published their epoch-making study, *500 Criminal Careers,* in which it was shown, as a result of painstaking investigations, that incarceration and treatment in a reformatory did not result in subsequent high rates of reformation. Of those released on parole, 61 per cent proved to be failures during the parole period, being guilty of new crimes or of other gross misbehavior. Of 422 whose post-parole behavior was traced for five years, almost 80 per cent had committed new offenses.

Disheartening as these statistics appear, they nevertheless represented an improvement over corresponding results among a group

of juvenile delinquents. This suggested the desirability of studying the lives of the reformatory parolees for a second period of five years, following immediately upon the close of the first five-year interval. If reformatory inmates showed higher rates of improvement than juvenile delinquents, was it not possible that the former would continue to show improvement with the passage of time? This is precisely what is disclosed by the investigations detailed in *Later Criminal Careers.*

Of the original group of 510, 55 had died during the first five years after discharge from parole, and one died a few days after the end of the period, leaving 454 available for investigation during the second five years. The limits of the latter period fell in 1931 and 1932. What were the principal changes in this period?

In the first place, there was an improvement in environmental conditions. Homes were more adequate physically, and neighborhood conditions were more wholesome. There was some improvement in degree of industrial stability. Leisure time was used more effectively. There was no improvement in economic conditions. The most important finding, however, was the fact that 32.1 per cent of those whose histories were known were non-delinquent during the second period, compared with only 21.5 per cent during the first period.

Having established this important fact, the authors sought its cause, and after eliminating all other associated conditions, they came to the conclusion that age was the principal significantly related factor. As the subjects of these studies grew older, they underwent certain psychological transformations. They became more stable. There was marked improvement in their family relationships, and an assumption of greater economic responsibility. In other respects, too, they showed evidence of the settling-down process. This sort of behavior is exactly what one would expect as a result of maturation.

The favorable results were limited largely, however, to those who, when released, were comparatively young. Among the older cases —*i.e.*, those over thirty-six—the changes were unfavorable. It appears, therefore, that reformatory inmates may be divided into two classes with respect to the chances of improvement in behavior. One group, relatively young when sentenced, showed improved behavior with advancing age. The other group, relatively old when convicted, seem to have been selected from a population largely irreclaimable from criminal pursuits. The two types differ fundamentally in that the older group included relatively more cases of

emotional instability and of mental aberration, conditions that may be regarded as constitutional.

Important conclusions flow from these studies with respect to the individualization of treatment in reformatories. It is useless to expect the same results from such divergent types of human being. It is desirable, therefore, that in sentencing prisoners, and in subsequently selecting those adapted to parole, discrimination be exercised, and that "punishment be made to fit not the crime, but the criminal." As in their earlier works, the authors present a prediction table with respect to probable outcome of behavior during parole. Theoretically, such a tool is highly desirable. How well it will work in practice can be learned only through experience, and it is to be hoped that parole authorities will sooner or later determine whether such methods will prove of real utility in the treatment of offenders.

In their book the authors have made another fundamental contribution to our knowledge of criminal behavior. It is to be hoped that they will find it possible to study what happens to other groups of offenders—*i.e.*, those committed to state prisons. Not only will such studies help in reshaping the methods and discipline of other types of penal institution, but they will complete the picture of the delinquent and the criminal as they are seen beginning with the juvenile court and ending with the courts of criminal jurisdiction.

BENJAMIN MALZBERG.

New York State Department of Mental Hygiene, Albany.

CRIME AND THE COMMUNITY. By Frank Tannenbaum. Boston: Ginn and Company, 1938. 487 p.

The title of this volume would naturally lead one to expect that the social aspect of crime would be stressed; in this instance, however, the individual's portion in the equation *individual* + *environment* = *conduct* is almost completely denied. The author's keynote is perhaps most succinctly expressed in the following quotation (p. 9):

> "The difficulty with the older theory is that it assumed that crime was largely an individual matter and could be dealt with when the individual was dealt with. Instead, most delinquencies are committed in groups; most criminals live in, operate with, and are supported by groups. We must face the question of how that group grew up into a conflict group and of how the individual became adjusted to that group rather than to some other group in society. The study of the individual in terms of his special physical or psychical idiosyncrasies would have as much bearing on the question why he became a member of a criminal group as it would on the question why he joined the Ku Klux Klan, was a member of a lynching bee, joined the I. W. W., became a member

> of the Communist or Socialist party, joined the Seventh-Day Adventists or the Catholic Church, took to vegetarianism, or became a loyal Republican. The point is that a person's peculiar physical or psychic characteristics may have little bearing on the group with which he is in adjustment."

Quite aside from the very doubtful premise that "most delinquencies are committed in groups," so wholesale a denial of the factor of individual differences must cause the reader to be somewhat suspicious of the balance or judicial nature of the author's attitude. He goes on to "repudiate explicitly" "the assumption that crime is caused by any sort of inferiority, physiological or psychological." In attempting to prove his point, he dismisses Lombroso and the Positivist School with a few words about Goring's "annihilating attack" (which was in fact a terrifying statistical superstructure built on sand); the psychologists and intelligence tests with a few quotations from early and overenthusiastic mental testers (1914 and 1916, for instance); and the psychiatrists with references to some early surveys and to certain comments by non-psychiatrists. Yet a chapter is devoted to classification of the prison population; and segregation of the insane and the feebleminded, and "complete removal" from the prisons of sex perverts, are recommended. He then continues (p. 356) "It is clear that each of the remaining prisoners requires special consideration and that mass treatment ought to be avoided"! Such a statement, and the statement that 20 per cent of the prison population need permanent separation, are rather hard to reconcile with an explicit denial of individual differences. It would appear reasonable to assume that if individual treatment is called for, it may be for reasons that have something to do with the offender's present situation.

The volume is divided into three parts: *The Criminal Pattern; The Administration of Criminal Justice;* and *Punitive Processes.* Part I deals with such matters as social forces in the development of crime, organized crime, politics and police, and past theories of crime. Part II paints a black picture indeed, although many of the charges made are matters of record and undeniably true. Part III is the most successful part of the book, and the chapters on the penal system, prison labor and industry, and parole and probation, are, to the reviewer's mind at least, excellent. It is unusual to find so little questioning of the present method of sentencing, and a complete lack of reference to the possibility of a "treatment tribunal" along the lines suggested by Sheldon Glueck; but perhaps anything savoring of the individualization of correctional treatment would conflict with the author's philosophy.

Although a number of authoritative studies are quoted, one notes numerous quotations from the daily papers or quasi-popular treatises.

Regardless, however, of one's philosophy or criminological beliefs, one can agree heartily with the author in his conclusion that "if we have learned nothing else from our experience, we have learned that to send a criminal to prison is almost to make certain that we shall have the task of sending him again, after his release . . . The present method of punishment is an empty and expensive exercise in futility, ending only in chagrin and bitterness and further crime and further punishment. We need an alternative to punishment."

The volume is stimulating and interesting, and serves to emphasize the gloom and ignorance that surround the present state of criminology, and the need for light and yet more light.

WINFRED OVERHOLSER.

Saint Elizabeths Hospital, Washington D. C.

BIOLOGICAL TIME. By P. Lecomte du Noüy. New York: The Macmillan Company, 1937. 180 p.

This very interesting book commends itself along three separate lines. First of all, it is an able essay in the direction of bridging the gap between biological and inorganic phenomena. The author has chosen his biological study along lines that permit measurement and calculation, and these, when completed, lend themselves to comparison with physical and chemical phenomena of the inorganic world. From this he derives the idea that time perception is probably physico-chemical in nature. If one superimposes the curve of the apparent shortening of one year derived from the author's coefficient of physiological activity upon the curve of the value of a year expressed in fractions of the age of man, there is a striking tendency to coincidence. The type of curve is one commonly encountered in chemistry. Biological time—the rate of cellular repair and reproduction—flows more slowly with advancing years when compared to physical time. Conversely, physical time flows more rapidly in relation to biological time as the age of the individual increases. As a consequence, any fixed period of physical time appears longer and is of much more value in youth than in old age. "Young and old, united in the same space, live in a separate universe where the value of time is radically different. Pedagogues and psychologists do not seem as yet to have taken into account the considerable importance of this disaccord." From his data and by comparison with electronic phenomena, the author draws the conclusion that continuous, physical, or universal time is a mere conceptual envelope of our physiological time. "Each one of our senses acts as a receiving

set and translates for our consciousness the silent, invisible, and abstract message of the quanta of energy. It is in this sense that we have occasionally called our physiological time real time. It is owing to this time that the summation of quanta takes place in our brain, and that we perceive the universe as we perceive it."

The book's second claim to commendation lies in the fact that each progressive step in the argument is supported by experimental fact, the nature and data of which are clearly stated. This constitutes, then, a collection of reports on exceedingly varied biological studies, ranging from the rate of cicatrization of wounds and rate of growth in tissue culture to the experiments from which the chemical nature of immunity became clarified. These, to the reviewer, are fascinating passages and stimulate the imagination along further experimental lines.

The third point on which the book merits special commendation is that the author lets us behind the scenes of his thinking, so that the reasoning which leads from one step to the next is perfectly clear. This is so rare in books that it seems almost an innovation. It is certainly refreshing.

There can be no criticism of the arrangement and printing of the volume. Its one fault lies in the nature of the material dealt with. Although the author has done much to simplify this material, in many places it is so technical as to be obscure to any reader who has not a certain range of scientific and mathematical knowledge. The reviewer believes that this may restrict the circulation of the book to a smaller circle of readers than its quality deserves.

LAWRENCE F. WOOLLEY.

The Sheppard and Enoch Pratt Hospital,
Towson, Md.

ABNORMAL PERSONALITY AND TIME. By Nathan Israeli. Lancaster, Pennsylvania: The Science Press Printing Company, 1936. 123 p.

This book offers a new orientation with regard to the attitudes toward time of psychotic patients. The first chapter is a brief review of the literature on the psychopathology of time, the author apparently concentrating on the points that are more or less pertinent to his own investigations. Part II consists of four chapters, the first three presenting, respectively, the outlooks toward time of a depressive, a paranoid schizophrenic, and a manic patient, while the fourth is devoted to the "future autobiography" of a paranoid schizophrenic. These case reports are of great interest in that they represent a fairly good sample of one of the techniques the author utilizes. In spite of its interest and its evidences of careful investigation, however,

this section of the book leaves one somewhat uncertain as to what application the author intends to make of the facts presented. This uncertainty is not entirely cleared up except that one gathers that the cases are intended only as illustrations of a technique.

Part III discusses abnormal mental processes in relation to time experience. It consists of two chapters, the first of which is devoted to a detailed analysis of the time attitudes of a group of thirty-seven paranoid schizophrenics. In these patients the author finds that verbal expressions, attitudes, and delusions affect the nature of the experience of time. The general pattern of the outlook upon the future varies among them, but there is an unusually high percentage of limited outlook patterns. The notion of the passage of time appears to be retained in almost all cases.

The second chapter in this section gives the results of the application of the author's questionnaire technique to a group of mental patients whose diagnoses were unknown to him. When these data were compared with clinical diagnoses, he found that in general each diagnostic group tended to answer the questions in a way characteristic for that group, although in each diagnostic group there were questions answered in the pattern of each of the other diagnostic groups. He does not comment on the fact, but in each case well over half of the questions were answered in a normal fashion. He concludes from this distribution that such statements by mental patients can be judged with respect to abnormality and kind of abnormality, but that the scattering of scores among all types of mental disorder might be due to errors of judgment or to a spread of psychotic traits and characteristics which might imply that the differences between mental patients are quantitative and not qualitative. Thus, it would be possible to describe a psychotic individual as melancholic in some respects, schizophrenic in some, manic in some, neurotic in some, and normal in some; differentiation would depend entirely upon the quantitative distribution. The data presented do not logically justify any such supposition, the author skipping too lightly over the isolated character of the phenomenon under consideration. This does not, however, detract in any way from the interest and value of the material.

Part IV deals with "future autobiographies" of psychotics and of superior adolescents. This section is of particular interest because of the differences exhibited by these two groups, which would seem to indicate that genius and mental disorder are not nearly so closely related as has been supposed by many writers.

Part V presents the author's summary and conclusions.

The reviewer and all workers in this field are indebted to the

author for opening a new approach and devising and presenting us with tools for further investigation. It seems fair to say that the majority of us will be able to make many useful adaptations of the author's techniques. On the whole one, is impressed with the soundness of his discussions and criticisms and the accuracy and thoroughness of his observations. Whether the work really marks a "milestone in the development of concepts needed for a clear realistic, and useful social psychology," as the writer of the Introduction states, remains to be seen. In any event, the book will be found useful and interesting.

LAURENCE F. WOOLLEY.

The Sheppard and Enoch Pratt Hospital,
Towson, Md.

FOUNDATIONS OF CHARACTER AND PERSONALITY; AN INTRODUCTION TO THE STUDY OF SOCIAL ADJUSTMENT. By George Herbert Betts. Edited by Raymond A. Kent. Indianapolis: Bobbs-Merrill Company, 1937. 371 p.

The output of books on "personality adjustment" or, more frequently, "maladjustment," is bewildering in amount, gayety of jacket, and vivaciousness of style. In the last two or three years such books have been published with startling rapidity, and the colloquial manner in which information is imparted often carries the implication that one has only to go through certain prescribed motions, listen to and repeat a few well-chosen words, and the deed is done.

For this reason it was something of a relief to the reviewer to open a serious-looking volume, not too large, but solid, and find the contents presented in more or less textbook style, with references and questions at the close of each chapter. The author was for many years professor of education at Northwestern University, and he approaches his subject from the point of view of an educator. Technical terms of a psychological or psychiatric type are at a minimum, and illustrations are mostly drawn from groups and individuals in the community, not in clinics or hospitals. The references for additional reading cover a wide field; all points of view are represented, but the references that are starred as of most importance are almost all to books on education or social or abnormal psychology of a behavioristic type—that is, not psychoanalytical in trend.

The volume, the Preface tells us, is a posthumous work. Dr. Betts died suddenly, after having written only one chapter of it. He had left abundant notes, and the other chapters are the work of colleagues. The Introduction, by Dr. John E. Stout, also of Northwestern University, and the final chapter by Dr. George E. Hill, of the University of Pennsylvania, are particularly stimulating.

The book abounds in definitions, and every effort is made to make clear the words and phrases so often used glibly and with the vaguest ideas as to their meaning. For instance, in a thoughtful discussion of attitudes as motives for conduct, the author accepts "the definition that treats attitude as a *tendency* to overt action . . . *providing* that in overt action we include *inhibition*" (p. 205; italics the author's). He then discusses the relation between attitudes and ideals and again states that here is a word which has not yet acquired an exact definition universally accepted. He defines ideal as "any generalized pattern of behavior which becomes the objective of desire and purpose." All through the book, he attempts to include such terms as attitude and ideal—usually thought of as outside the purlieus of academic psychology—in a systematic treatment of personality. He thereby makes a real contribution to clear thinking, for in actual living attitudes and ideals are surely as important as reflexes and innate urges—or whatever term is used to denote what used to be called instinct.

It is a question whether the inclusion of chapters on delinquent and perverse behavior is wise, considering the brevity of the book and its positive and overt concept of character and personality. So much study of a more analytic nature has been carried on in this special field that it is here the present volume seems most inadequate. The final chapter, *Integration of Character and Personality,* gives emphasis of a practical nature to the book's main thesis and also insures it a place all its own in the flood of books on this general subject now overwhelming us. The relation between "conscience" and the social *mores,* the connection of integration with habit, the important part to be played by education in bringing about better human relations—of man to man and of man to himself—these ideas are clearly and constructively presented.

One particularly stimulating section is that on belief and knowledge and their importance in motivating conduct. The connection between belief and delusion, often so close; emotional elements in belief; the relation of belief to knowledge—"Many beliefs which men hold are therefore stages on the road to knowledge"—and the later statement: "Belief is a guess at certainty of fact or truth; an attempt to go beyond knowledge into the grasp of reality" (p. 281)—all help toward a realistic view of man's complex mental life.

Although many may miss the treatment of a deeper psychological analysis, it seems to the reviewer that here is an outstanding contribution to the study of personality and character.

ELEANOR HOPE JOHNSON.

The Hartford Seminary Foundation.

THE NATURE OF HUMAN NATURE AND OTHER ESSAYS IN SOCIAL PSYCHOLOGY. By Ellsworth Faris. New York: McGraw-Hill Book Company, 1937. 370 p.

Dr. Faris refuses to believe that conflicts between races, classes, sects, and nations are forever incapable of peaceful resolution. Because they are the acts of human beings, he permits himself to hope that they may be better understood than they are now, and that an adequate science of human nature may offer much practical guidance. He speaks out of some four decades of study in sociology, ethnology, and social psychology.

The leading thought of the book is that personality is an acquisition, chiefly of social origin. Hence we are properly warned that to speak of human nature as unchangeable is to forget how group customs have indeed been changed under the pressure of such social forces as war, changing economic influences, and the like. Fatalism about the "femininity" of women, for example, sounds foolish to-day in the light of the many activities now carried on by women that once upon a time were deemed unthinkable for them. Children of immigrants differ more markedly from their parents than if they had all remained in the old home. Errors such as McDougall's belief in separate degrees of instincts for separate races might have been avoided if more study had gone into the social attitudes and the social organizations in which these supposedly fixed expressions are fostered or discouraged. Personality has no existence apart from group experience. The meaning of an individual's acts is contributed perhaps in largest part by other people. If facts like these had been better grasped, unreliable writers like Pareto would not have risen into wide notice.

Dr. Faris pleads for more reciprocity between sociologists and educators. Juvenile delinquency, for instance, "has many and varied causes, but one important source which contributes to the unwanted result is the spiritual isolation between young people and their elders. It is not doubted that we are given the confidence and allegiance of the children to start with. It is incontrovertible that we usually lose it to a large degree. It is arguable that the bond is never broken in the first instance by the child, but rather by the erroneous procedure of the adults. . . . Whether we have found the solution is not so important. What is important is that the problem should be recognized as a problem" (p. 214).

"Drives and tendencies are created in social experience, and the older and undesired ones can be replaced by later and more valuable urges. The energies of parents and teachers should be devoted to the task of so controlling conditions that new and powerful motives

may lead to high endeavor in the interest of social welfare. He who deals with children will do well to ponder the profound saying of Dewey that it is the institutions which create our instincts" (p. 233).

Most of the book consists of papers already published separately. This is hardly to be regretted in as much as the things which the author says are greatly in need of publication in this more convenient and non-technical form.

HENRY NEUMANN.

Brooklyn Society for Ethical Culture.

GENERAL PSYCHOLOGY FROM THE PERSONALISTIC STANDPOINT. By William Stern. Translated by Howard D. Spoerl. New York: The Macmillan Company, 1938. 589 p.

This excellent translation of the German text presents a synoptic revision of the whole field of general psychology from the *personalistic* point of view. Personalistics takes as its subject matter a distinct concept of "the Person," whose goal-directed uniqueness and totality in relation to outer reality is epitomized by the term *unitas multiplex*. The theory of personalistics emphasizes subjectified and objectified experience rather than consciousness as the outstanding characteristic of the mind. Psychology, redefined, is thus "the science of the person as having experience or as capable of having experience."

Viewed personalistically, human life is represented in three categorical "modalities," designated by the concepts of "vitality," "experience," and "introception." Introception is defined as the coalescence of the world of objective values with the person's own substance. The dynamic aspects of experience are reflected in the concepts of "cleavage" and "tension" (*Spaltung und Spannung*), and its special characteristics are revealed in co-existing and successive rhythms of "salience" and "embedding" within the unity of the person. Dispositional trends (distinguished from mental "faculties") are viewed either as latent "implements" or as "directional determinants" of personal functioning. *Personal* dispositions, whether actual or potential, are no longer exclusively mental or physical, but are "psychophysically neutral." The personalistic theory incorporates the dimensions of space and time as special modes of experience which are psychologically interfunctional.

The book itself is divided into six parts, the general arrangement of the material following that of traditional psychology texts. The first part serves as an historical survey, and includes a concise abstract of the personalistic principles which are more fully developed in the author's other works. These formulations constitute

the framework for further interpretation throughout the book. A section is devoted to each of the following major topics: perception, memory, thought and imagination, volition, and feeling.

Sense perception is approached from the Gestalt point of view, emphasis being placed on the alterations resulting from the salience and embedding of all impressions in the light of their *personal* significance for the individual. Memory is defined as the conditioning of experience by the past, and the mneme, in its distinct personal relationships, occupies the middle ground between instinct and intelligence. Thinking, manifest in essentially salient experiential wholes, is at the same time an activity deeply embedded in the total person. Intelligence is defined simply as "the personal capacity to meet demands by making appropriate use of thought as a means." The emancipation of intellectual activity from primal personal levels is traced through the hierarchy of perception, memory, thought, and finally creation.

Emotion and will are comprehended as higher stages in the progressive spiritualizing of basic vital drives. The dual nature of *personal* activity is shown in the conception of the person-world relation as an endless oscillation between spontaneity and reactivity. "Character" has meaning only as a totality concept, and is defined as a unitary, *personal,* and psychophysically neutral "setting of will" that possesses internal cohesion and a developed total organization. Feelings have a patternless *Ungestalt* ranging on a wide scale from unconsciousness to salient awareness. This section of the book concludes with a tripartite classification of feelings on the basis of their temporal significance. On a similar four-field table, paired opposite the pleasure-pain component, moods are classified as active or passive, emotions as violent or enervating, and temperaments as exciting or tranquillizing.

The personalistic theory is based on a rational, common-sense approach, taking for granted a trans-biological interpretation of human life which leads naturally to further development of the philosophical rather than the physiological aspects of its subject. Limited to a purely and exclusively "normal" psychology, Professor Stern does not in this book attempt to extend his theoretical formulations into the field of psychopathology. One handicap which goes beyond his responsibility is the inevitable loss of meaning incident to translating into a new language such bipolar euphonisms as *Lebnis-Erlebnis, Schein-Erscheinung, Gestalt-Ungestalt, Rüstung-Richtung,* about which so much of the discussion is centered. The classically "textbook" style of the book, with its methodical classification and labeling of concepts, makes reading uneven and tends to transform certain portions into a compendium of personalistically

revised definitions. A certain stereotypy in fitting the subject matter into the preconceived personalic framework exposes the author to the same criticism of monistic interpretation that is directed against the proponents of the various schools of depth psychology.

No critical considerations in this vein, however, can detract from the stimulating and constructive aspects of this important and forward-looking work. It is a solidly written, scholarly contribution, well grounded in established nineteenth-century doctrines, and sufficiently flexible to be adaptable to modifications which further applications will undoubtedly demand. In emphasizing the common background and permanent unity of the personal life, Professor Stern's doctrine brings to academic psychology the same broadening influence which the psychobiologic teachings of Adolf Meyer have contributed to American psychiatry.

LEONARD E. HIMLER.

University of Michigan, Ann Arbor.

EXPERIMENTAL SOCIAL PSYCHOLOGY. By Gardner Murphy, Lois Barclay Murphy, and Theodore M. Newcomb. Revised edition. New York: Harper and Brothers, 1937. 1,121 p.

This encyclopedic volume of over 1,000 pages, with a bibliography of 1,111 titles, is a complete rewriting, with the collaboration of Theodore M. Newcomb, of Gardner Murphy's and Lois Barclay Murphy's *Experimental Social Psychology.*

The earlier volume, first published in 1931, has become something of a classic in social psychology, partly because of its emphasis on, and comprehensive survey of, the experimental work in the field. Since then, research in, and on the fringes of, social psychology has proceeded at an accelerated pace. The difference between the two volumes, however, is not only that the second brings the summaries of experimental literature up to date. In the Foreword, the authors state that they will "not attempt a handbook of research findings, such as the first edition represented, but a somewhat more *systematic interpretation of the evidence* . . . regarding the relation of human beings to one another *in our own culture.* The emphasis is not upon group behavior as such, but upon the processes by which the individual responds, from infancy onward, to the persons about him, and becomes an adult personality in our society —broadly, the process of *individual socialization.*" (Italics the reviewer's.)

Some of the keynotes to the present volume are contained in these introductory remarks. Throughout the book, in the examination of research findings as well as in suggesting concrete problems for

future research, the authors stress the fact that social psychology deals not so much with an essential and invariable human nature, but rather with human nature—or behavior—as it is actually found under the molding influences of the social and material environment. Again and again, they call for a more fundamental analysis of the differential aspects of our particular culture, and of the variations in social and economic conditions in their bearing on various aspects of social behavior and attitudes. This outlook seems a very healthy sign indeed in the development of social psychology.

As regards the "systematic interpretation" of the subject matter of social psychology, which the authors set for themselves as a goal, their orientation toward the material, their notion of what social psychology is about, is best summarized in the expression "the socialization of the individual." In fact, the term appears in the subtitle of the book. Around this point, the whole treatment is centered. Eventually the conclusion is reached, on the basis of the voluminous evidence reviewed, that "basic social laws" can never be formulated, except in terms of the individual. Social psychology remains essentially an individual psychology. However, when one comes to the last chapter, *The Measurement of Social Attitudes*, one finds a somewhat different emphasis. The concept of social attitudes is conceded to occupy a "nearly central position" in social psychology. Moreover, these attitudes are viewed not as individual and personal affairs, but as "largely borrowed from the group to which we owe our strongest allegiance."

The definition of social psychology as largely a "psychology of the individual," in which, to be sure, social factors play a relatively large part, seems difficult to reconcile with the rôle assigned to social attitudes in the last part of the book. In fact, the whole last chapter seems somehow to fall outside of the main systematic orientation of the rest of the book. This difficulty, on the part of such eminently competent writers, in arriving at a systematic orientation that will, at the same time, do justice to all the available material, raises interesting speculation as to the present and the future of social psychology. It is just barely possible that the future social psychology will be written less in terms of the individual and more in terms of social phenomena.

The excellent discussion of the place of experimentation in social psychology must be mentioned. The authors complain—and with good reason—that the social psychologist has "simplified his phenomena in such a way as to exclude essential facts necessary in the understanding of social life, and has succeeded in experimental and quantitative control by leaving out most of the variables about

which we really need to know." Experimentation is here placed in its proper perspective as only one of the methods at the disposal of the worker in this field. Experimentation, we are told, comes relatively late in the development of science—"after the problem has been defined, and its salient characteristics so well formulated that we know what can be controlled and measured." The stage of clear definition of significant problems has obviously not yet been reached in social psychology. The result has been a blind and mechanical use of experimentation, which could lead only to a relatively futile and sterile accumulation of data. That no completely satisfactory systematic synthesis has been reached up to the present time is a result of the completely unsystematic manner in which the hundreds of scattered researches on ill-formulated problems have been conceived.

In view of the somewhat chaotic stage in which social psychology finds itself, the authors have rendered the student and the research worker an invaluable service in attempting a synthesis of the material. The task is a stupendous one. Certainly the present state of social psychology is presented here more completely than has ever been done before.

For the convenience of the reader, the experimental material on various topics is summarized in charts. But the reader is considerably inconvenienced by the awkward way in which references are given in the text itself. At the back of the book, one finally discovers a guide to pages and paragraphs of the text which in turn gives specific references to the final bibliography. Thus two separate entries must be consulted, making the hunting down of chapter and verse referred to in the text a cumbersome procedure.

HANNA F. FATERSON.

Smith College, Northampton, Massachusetts.

SOCIAL BEHAVIOR AND CHILD PERSONALITY. By L. B. Murphy. New York: Columbia University Press, 1937. 344 p.

In this volume, L. B. Murphy makes a broadside attack on the problem of sympathetic behavior, having apparently arrived at the realization that any adequate answer to the question of the nature and determinants of sympathy must include most of the forces of the universe. Would it were realized generally that all problems of determination, barring perhaps those of specific localized differences, are stupefyingly large. We see fit to set limits to these problems merely for the sake of some progress in understanding and, I should add, for the sake of our sanity. Since we must abstract and ignore in order to understand at all, it is my belief that the task of the

scientist is the difficult one of trying to discover the most powerful vectors in the difference phenomena of special concern to us for one reason or another, and to couch his explanations either in the most parsimonious or the most specifically useful terms. In the end these two objectives may be the same. If this thesis be correct, I would argue less than Murphy does about the abstracting as such that has occurred in the study of various forms of behavior—*i.e.*, the ignoring of the "total personality" setting of behavior patterns —and would argue more about the usefulness for specific purposes of details that have been currently blotted out of the picture by experimenters. If I had to drag along the "total personality" (assuming I could know what this is) I fear my thinking would be chained to the spot.

Murphy's interest in the ramifications of the determinants of cohesive social behavior has resulted in the production of a discursive work rich in hypotheses. These hypotheses adduced by logic are proffered us with supporting evidence of varying degrees of concreteness and convincingness. In only a few cases have the more formal of our techniques of analysis been used with sufficient refinement to establish a high degree of probability for the propositions suggested. This does not mean that even such theories as are presented with little more support than what seems an apposite example or two are not tenable. In fact, so plausible are most of the hypotheses that I should expect them to be established as highly probable were more adequate methods employed.

In order that the reader may envisage in more detail the terrain of Mrs. Murphy's exposition, let me enumerate some of the specific tasks she sets for herself: (1) the suggestion of a cultural setting for many of the patterns of the sympathetic and unsympathetic behavior observed in American children; (2) the demonstration, when behavior is viewed with respect to its positive social temper, of great variability in the individual from situation to situation and hence of the danger of pigeonholing persons after observing them under only a limited number of circumstances; (3) the suggestion of qualities and values within children that may color their sympathetic behavior or deflect them from the latter; (4) the determination through group comparisons of the weight that sex, age, and intellect variables have within the range of social phenomena focused; (5) the picturing of behavior sequences that would tend to suggest the pattern of incrementations that might be viewed as the course of the development of sympathy; (6) the creation of some stimulus-and-response classification schemes useful in analyzing coöperative conduct; and lastly (7) the derivation of some techniques for record-

ing, as well as for providing opportunity for the observation of, sympathetic behavior.

While, as we stated earlier, Murphy is interested primarily in setting forth her theories, she presents evidence drawn largely from the returns accrued as a result of observation of the reactions of several groups of young children to distress situations. Thirty-four children enrolled in two nursery schools, representing somewhat different socio-economic levels, were observed carefully during their free play periods for about eight months, while several other groups were under inspection for less extended intervals. The observer attempted to describe each distress situation that occurred during the play sessions and the reactions of the children to these. The selection then of the situation-behavior constellations to be studied was first in terms of the stimulus—*i.e.*, the distress situation—rather than in terms of the response. Since, however, sympathetic behavior was the point of convergence of the author's interest, those distress situations which elicited no sympathetic response received scant attention.

In addition to collecting the protocols just described, the author developed and used a rating-scale inventory composed of items descriptive of coöperative and antagonistic behavior. She also devised a series of semi-controlled "test" situations designed to facilitate the exposure of children directly or indirectly to suffering in other human beings or animals. In these test procedures, the rating blank, and the stimulus-and-response classifications schemes, the study may be said to offer technical as well as theoretical contributions, though the former are not major. The classification schemes employed are, for instance, not strictly logical, the relationships of coördination and subordination often being obscured or ignored. They do, however, seem to make possible with a fair degree of success the alignment of evidence with respect to certain issues of interest to the author.

Among the findings with which the investigation presents us are the following: 1. The relative frequency and the patterns of sympathetic response varied somewhat in the two groups of young children observed most systematically. 2. No consistent sex differences in general responsiveness to distress were noted; but boys, as contrasted with girls, tended to exhibit more of such aggressive forms of social concern as the active defense of another. 3. The readiness with which sympathy could be aroused, as well as the forms in which it showed itself, tended to alter with age, efforts in the direction of direct removal of the causes of suffering, for example, increasing with the years. 4. There seemed to be a low positive correlation between frequency of sympathetic response in the situations observed and intellect, as well as some difference in the pattern loadings of

bright and dull children. The brighter children seemed to sense needs when the less bright failed and also to perceive more readily ways of directly relieving the distress they beheld. The more intelligent were less inclined than the dull to resort, for instance, merely to a sympathetic howl. 5. The incidence of sympathetic behavior was positively correlated, in the age range explored, with the incidence of aggressions. (The author believes that the more aggressive children tend to engage more often in the active and directly protective kinds of sympathetic responses, while the more timid are more likely merely to warn those in danger or to offer advice.) 6. Only 169 examples of sympathetic behavior were witnessed during 216 hours of observation. It is estimated that in an equivalent amount of time eight times as many examples of antagonistic behavior would have been observed. 7. Marked variations in the behavior of the same individual from situation to situation were noted, as were also individual differences in the ratio of the number of sympathetic responses given to the number received; in the number of persons for whom concern was shown; and in the relative frequency of the various types of sympathetic response. 8. The ratings made by the teachers of the children in accordance with the rating scale yielded scores which correlated from +.45 to +.86, depending on the raters, the group, and the occasion. Sympathy scores obtained from the systematic observations of the children yielded reliability coefficients (odd-even days) of +.94 to +.99; while the rating scale had a reliability of +.88 when the scores for odd and even halves were compared. The teachers' ratings and the observation scores correlated about +.80. 9. Competing self-interests clearly inhibited, on occasion, tendencies to sympathetic behavior. (This was especially clearly shown during the test situations.) 10. Furry animals seemed to elicit more sympathetic responses from the young children than did fishes and frogs.

It is a major thesis that the ambivalence in our cultural code reflected in our various competitive practices, as contrasted with the responsibility we are taught to assume for the protection of the underdog, provided he is far enough under, is responsible in part for the inconsistency we behold in the behavior of young children.

In its lack of conciseness—its essential content could have been set forth in one half the space—Murphy's volume can scarcely be offered as a model, but it has certainly helped to crystallize the problems, and it should stimulate an enthusiasm for illuminating some of the relatively dark areas of the psychological field.

HELEN L. KOCH.

University of Chicago.

DYNAMIC CAUSES OF JUVENILE CRIME. By Nathaniel D. M. Hirsch. Cambridge, Mass.: Sci-Art Publishers, 1937. 250 p.

In this volume Dr. Hirsch, State Director of the United Public Health Survey, New Jersey, offers a well-constructed report of an analysis of 604 juvenile-delinquency cases taken from the records of the Wayne County Clinic for Juvenile Delinquency, Detroit. The fact that Dr. Hirsch has had five years of intensive personal experience as a clinical psychologist entitles his report to careful study.

The book opens with some basic observations regarding the *necessity* "of formulating hypotheses and of creating theories before approaching facts." Chapter I sets up four causal categories: heredity, environment, accident, and genius. Chapter II reviews briefly certain recent studies on juvenile delinquency. Chapter III offers a helpful analysis of the scientific spirit and its relation to the social sciences, and explains the sources and history of the data of the book.

The body of the book treats of the following topics: etiological factors leading to the delinquency in the 604 cases studied; statistical analysis of a group of broken as compared with a group of unbroken homes; intra-familial rank and age differences as factors in the causation of delinquency; general intelligence and the mechanical ability of juvenile delinquents as compared with those of the normal child; enuresis in relation to delinquency; summaries of individual case reports; and suggestions for combating the general delinquency situation.

This book is plainly an earnest effort to treat honestly of the causes of juvenile crime and is deserving of careful reading. It is written in a positive style, and its content is thought-provoking. The author is an enthusiastic advocate of improving heredity factors as an aid in attacking the delinquency problem. Instructive clinical data on actual individual case reports make up nearly half of the book. The chapter on enuresis and delinquency is interesting and stimulating. Chapter V, the statistical analysis of broken and unbroken homes, is especially noteworthy.

JOHN M. DORSEY.

University of Michigan, Ann Arbor.

NOTES AND COMMENTS

Compiled by

PAUL O. KOMORA

The National Committee for Mental Hygiene

NEW HOSPITAL FOR DRUG ADDICTS OPENED AT FORT WORTH

The second United States Public Health Service Hospital for the treatment of drug addicts was dedicated at Fort Worth, Texas, on October 28, 1938.

Surgeon-General Thomas Parran, who delivered the dedication address, outlined the history and nature of drug addiction and the evolution of social thought that led up to the construction of hospitals to replace the unsatisfactory method of caring for convicted drug addicts in prisons. He also explained the necessity of providing more adequate means than now exist for the treatment of voluntary patients and for the carrying on of research in drug addiction.

The first hospital of this type, located at Lexington, Kentucky, has been in operation for three and a half years, and more than 3,900 patients have passed through its doors. It has proved itself useful, both as a treatment and as a research center. The Fort Worth hospital will carry out the same general purposes as the Lexington hospital, but with some modifications in details which have been provided for through a different type of construction. The hospital section of the Lexington unit is contained in one large building, covering eleven acres, in which are concentrated the infirmary, the continued-treatment unit, the custodial unit, and the research laboratory, together with other facilities that go to make up a modern hospital. This form of construction was decided upon at Lexington in order to provide a maximum of custodial supervision, so that the most difficult patients, from the standpoint of custody, could be taken care of there.

The Fort Worth institution is composed of a group of attractive buildings, designed to take care of the more tractable types of patient in an environment in which custody is minimized. It is located on a 1,400-acre tract four miles from Fort Worth, and in addition to the farm is provided with shops and other facilities designed to furnish occupational therapy of a constructive type to the maximum number of patients.

The Lexington hospital will continue to be the most important research center, as it has been provided with special laboratory facilities, including an electroencephalograph apparatus, a metabolism chamber, and other equipment designed for physiological and chemical studies, but research into the psychology and etiology of drug addiction will be carried on at both institutions.

The Fort Worth hospital now has a capacity of 285 patients. This will be increased within the year to 1,000. The staff, based on present needs, consists of seven full-time medical officers, six medical consultants, three dentists, a psychologist, a laboratory technician, a librarian, trained nurses, and other personnel in adequate numbers. The medical officer in charge, Dr. William F. Ossenfort, was formerly on the staff of the Lexington hospital. He has had wide experience in the treatment of drug addicts and prisoners.

Most of the patients will be federal prisoners. Any citizen of the United States who is addicted to opium, cocaine, cannabis indica, or peyote, or any preparation or derivative of these four drugs, is eligible for treatment as a voluntary patient. There are no facilities for the treatment of women at Lexington or Fort Worth, but a unit for women will be ready at Lexington early in 1940.

LAWRENCE KOLB.

MENTAL HYGIENE IN HAWAII

Hawaii is the latest newcomer to join the van of mental hygiene in its progress around the world. Interest in the movement in this Pacific outpost of the United States was first stimulated by a visit of Clifford Beers to Honolulu in 1931. The Governor of Hawaii at that time appointed an advisory committee of physicians and laymen to develop a plan for mental-health work, and by the spring of 1936 a provisional mental-hygiene committee was formed by the Hospital Social Service Association of Hawaii. At the invitation of an executive committee appointed by the Chamber of Commerce, Dr. Franklin G. Ebaugh, of Denver, Colorado, went to Hawaii that summer to make a survey of its mental-health problems. Thirty-five community agencies and organizations were represented in the working committee which sponsored the survey and aided Dr. Ebaugh in his studies.

Pointing out, in his report, some of the special characteristics of the mental problem of the islands, Dr. Ebaugh remarked that "much of mental illness has its roots in conflict and frustration situations in the family and the community, for Hawaii is racially mixed, with consequent cultural conflicts and with an unequal sex ratio which makes normal family life difficult." In addition, he said, the economic opportunities are limited by the island geography and industrial

development. As a result of his survey, Dr. Ebaugh recommended a reorganization of the psychiatric facilities and their administration at the Territorial Hospital, recodification of the laws governing the treatment of mental patients, the creation of a territorial psychiatric clinic, and the development of psychiatric departments in general hospitals.

Last summer Dr. Ebaugh went to the islands again to set up demonstration mental-health services, beginning with the organization of the Hawaii Mental Health Clinic at Queen's Hospital and the establishment of both out-patient and inpatient facilities for the treatment of mental cases. The provision at Queen's Hospital consisted of 11 beds with the required medical and nursing services, occupational therapy, hydrotherapy, and recreational facilities. The out-patient service was conducted on an appointment basis, and the services of a well-trained social worker, a consulting psychologist, and a secretary were available. A mobile clinic was also organized for the Islands of Hawaii, Maui, and Kauai, under the auspices of the county medical society. Some 150 patients were taken for study and treatment in the various units during the period of the demonstration. They were referred by doctors, by the courts, and by social agencies, and some came on voluntary application. There was a long waiting list. The educational activities of the clinic centered around numerous conferences with relatives and physicians, clinics held at Queen's Hospital, talks to the county medical society, and a series of talks on Oahu.

Dr. Edwin E. McNeil, former chief resident of the Payne Whitney Psychiatric Clinic of the New York Hospital, was appointed director of the clinic after the demonstration. "This clinic," Dr. Ebaugh writes, "was organized under the auspices of the Honolulu Chamber of Commerce and the Territorial Medical Society, and appears to be a very promising development, upon which the medical profession of Hawaii are to be congratulated."

Mental Hygiene and Science

As this is written, the stage is set for the Symposium on Mental Health to be held at Richmond, Virginia, during Christmas week, by the Section on Medical Sciences of the American Association for the advancement of Science. Featured as a high light of the association's meeting this winter, this unusual conference is expected to attract considerable interest among the large numbers who attend the numerous scientific sessions that make up the program each year.

Upwards of seventy contributions will be presented at the seven sessions of the symposium, dealing with many aspects of the subject.

Fifty of the papers, however, will have been published in advance, thus freeing the conference period for extensive discussion based on the pre-printed contributions. This basic series of papers, representing a sort of stock-taking of what is known about the mental-health problem at the present time, will provide a base line from which to build for the future, with the discussion program attempting to mark out the path of further advancement. The conference will seek, among other things, to effect a closer integration of psychiatry and mental hygiene with the various contributory sciences and disciplines, and to stimulate original thinking, to bring new ideas and fresh approaches to bear, with a view to a more concerted and effective attack on the whole problem.

The organizers of the symposium regard it not only as an exceptional opportunity for scientific discussion and study, but even more as "a stepping-stone to practical accomplishment, as a vehicle for the larger objective, which is to secure fruitful, nation-wide action looking to a solution of the problem in its immediate and remoter aspects." Out of the symposium, they hope, will come a national plan and program that will shape the development of policies and measures in research, treatment and prevention, administration, professional training, and public education in the mental-health field in the years to come.

Proceedings of Second International Congress on Mental Hygiene

The International Committee for Mental Hygiene announces that the proceedings of the Second International Congress on Mental Hygiene, held in Paris in the summer of 1937, are now available. The publication, edited by Dr. Réné Charpentier, chairman of the committee that arranged the scientific program, is in two volumes, running to a total of 900 pages, and containing a complete report of this eventful meeting. The communications of a hundred authors, covering a wide range of topics, are presented in several languages, predominantly in French, but with a substantial number of the papers in English. In addition, there are summaries of nearly all the papers in English, as well as in French, German, and Italian. The growing international-mindedness of the mental-hygiene movement is shown by the listings of national mental-health societies, leagues, and committees, and of the delegations from the many countries represented at the congress. A limited number of copies of the proceedings have been received at the New York office of the International Committee for sale at $3.00 per set. Orders should be sent to Clifford W. Beers, General Secretary, International Committee for Mental Hygiene,

50 West 50th Street, New York City. The comprehensive character of the proceedings, containing as they do a cross section of the latest scientific thought on the many-sided mental-health problem in the various countries of the world, makes them a valuable work of reference and source material to all students of the subject. An analytical index of authors and subject matter is included.

Fifth European Mental-Hygiene Reunion

Munich and the German Council for Mental Hygiene were host to the Fifth European Mental Hygiene Reunion held from August 22 to 25, 1938. While it could not be said to make history, like another and more famous conference held that summer in this early stronghold of Nazidom, it was not without consequence in its advancement of concerted studies of the mental-health problem by professional workers in the various countries drawn together by a scientific community of interest and a continental integration of mental-hygiene activities. The countries represented included France, Belgium, Italy, Sweden, Switzerland, Yugoslavia, Esthonia, Great Britain, and Turkey. The reunion devoted its three sessions, respectively, to the discussion of: "Marriage Prophylaxis and Mental Hygiene," "Prophylaxis for the Abuse of Intoxicants and Drugs," and "Occupational Therapy in the Treatment of Mental and Physical Illnesses." A full account of the conference appears in the October issue of *Mental Hygiene,* quarterly journal of The National Council for Mental Hygiene of Great Britain. The Sixth European Mental Hygiene Reunion is scheduled for Zurich next September, by invitation of the Swiss National Committee for Mental Hygiene.

A Setback for Politics in Massachusetts and Michigan

Some recent developments in mental-hospital administration encourage us to hope that 1939 may see a progressive amelioration of the political evils suffered by public institutions for the mentally ill in many of the states during the depression years. The distressing experience of Massachusetts, its state-hospital administration bedeviled by politics overnight, after a long and illustrious leadership in mental-health work, is a case in point. The crisis there was precipitated in 1936, with the enforced retirement from the commissionership of a "career" man, and his replacement by a political appointee, wholly devoid of the requisite training and experience, who has since been removed. After two years of struggle and turmoil, the situation in the state is more favorable. A progressive step was the enactment of an improved law reorganizing the Department of Mental Diseases and requiring, among other safeguards, that the

commissioner and assistant commissioner and all hospital superintendents shall be physicians certified by the American Board of Psychiatry and Neurology. Subsequently, Dr. Clifton T. Perkins, formerly acting commissioner of the department, and a diplomate of the American Board, was appointed commissioner. The new law also changes the name of the Department of Mental Diseases to the Department of Mental Health, in line with the growing emphasis on prevention and the activities of the department in this direction.

Michigan, with its new State Hospital Commission, under the direction of Dr. Joseph E. Barrett, formerly of the Massachusetts service and a diplomate of the American Board, has moved similarly to establish standards of appointment to high positions. At a recent meeting of the commission it was unanimously voted that in the future it be the rule of the commission that appointees to the position of state-hospital superintendent must be diplomates of the American Board of Psychiatry and Neurology.

Science and the Exceptional Child

The Child Research Clinic of The Woods Schools has just published the proceedings of its Fourth Institute on The Exceptional Child, held at Langhorne, Pennsylvania, on October 26, 1937, and attended by two hundred educators, psychiatrists, psychologists, pediatricians, and child-guidance leaders. A fifth institute, devoted similarly to a study of special problems of children, was held at the school on October 18, 1938. In a 61-page pamphlet this "exceptional" private school, which is distinguishing itself by its enterprising activity in the advancement of knowledge in this field, presents some of the "new contributions of science to the exceptional child," with special reference to four topics—namely, endocrinology as it relates to the understanding and treatment of the exceptional child, the present status of "Mongolianism," training opportunities for workers with exceptional children, and the psychological implications of motor development in children. Single copies of this and other interesting pamphlets issued by the school may be secured by addressing Miss Irene S. Seipt, Director, Child Research Clinic, The Woods Schools, Langhorne, Pennsylvania.

Spirochæta Pallida

A valuable summary of the present knowledge of syphilis, in thirty papers by thirty-three authorities on the subject, is presented in a publication by that title just issued by the American Association for the Advancement of Science. *Syphilis* is the third volume in the series reporting the symposia on important problems of public health which have been organized and held by the Section on Medical

Sciences of the association at its yearly meetings. Vastly enriching an already extensive literature on the *spirochæta pallida*, this new work illuminates and strengthens the scientific foundations for the nation-wide campaign now in progress for the eradication of one of the prime destroyers of physical and mental health, an endemic disease that counts its victims in this country by the million annually. Copies of the book may be obtained from The Science Press, Lancaster, Pennsylvania, at $2.50 per copy.

In furtherance of the campaign against syphilis, the American Social Hygiene Association is organizing the Third National Social Hygiene Day, to be observed on February 1. Initiated two years ago, to promote public understanding of the problem and public support for the program of control of the disease, this educational effort has met with wide response. Some 5,000 meetings are expected to be held to mark the day this year.

Mental-Health Observer

The Missouri Association for Mental Hygiene has recently put out another of its attractive "Mental Health Observer" series of booklets. Patterned after the *Reader's Digest* in format and style, the booklets make effective use of this enormously successful publication idea in presenting interesting selections from current writings on mental-health topics. The November issue, with its emphasis on mental hygiene for normal people, is an especially readable number, containing articles, excerpts, book reviews, and news on the national and local mental-health frontiers. Single copies, at fifty cents, are available from the executive secretary of the association, Mrs. Helen Sala, 107 Tavern Building, Columbia, Missouri.

The Cinderella of Medicine

Under this title Dr. Karl Menninger, in the November issue of the *Bulletin of The Menninger Clinic*, publishes an instructive paper on the rise of psychiatry among the medical sciences. It is a popular interpretation of the ascendancy of this branch of medicine in recent years and some of the factors that have contributed to its rapid progress, with the growing recognition of its importance by the medical profession. "Had we physicians recognized from the first that psychological and social factors are a part of medicine science," Dr. Menninger writes, "we could have made a better arrangement for the care of the mentally ill than now exists and better arrangements for other illnesses than now threaten." He points out that in several medical schools more time is devoted to-day to the teaching of psychiatry than to the teaching of surgery. No longer is psychiatry the Cinderella of medicine.

"Lost and Found"

Times are changing, and so are public notions on the subject of "insanity" and the mentally ill. A significant indication, among others, is that sufferers from mental ills, and their families, are shedding their wonted reticence in discussing the subject, encouraged by the wholesome change gradually taking place in the public attitude toward diseases of the mind. A striking illustration of this is the recent formation of the Association of Former Patients of the Psychiatric Institute in Illinois, as a further move toward the diffusion of enlightened concepts and attitudes and the eradication of the stigma traditionally attaching to mental disorders. The initiative for this organization, which meets monthly, with an attendance of several hundred patients and relatives, came from the clinical staff of the institute, which sought to keep in closer touch with its recovered and discharged patients and to aid more effectively in their adjustment to community life. At the same time, the doctors see in it the solution of the hitherto difficult problem of achieving an efficient follow-up technique, from the standpoint of statistical evaluation of therapeutic effort. The activities of the association include the publication of a periodical bulletin, entitled *Lost and Found*. Reminiscent of *A Mind That Found Itself*, it will carry on in the spirit of the author whose frank autobiography of that name made the breach in the barriers of public reticence and indifference and opened the way to a more intelligent attack on an age-old problem.

A Correction

In the article by Dr. Benjamin Malzberg, *Marriage Rates Among Patients with Mental Disease*, which appeared in the October issue of Mental Hygiene, the standardized marriage rates for female patients with general paresis are given on page 641 as 70.3 ± 0.01 as compared with 75.8 ± 1.19 for the general population. These figures should be reversed, the rate for the female patients being 75.8 ± 1.19 and that for the general female population, 70.3 ± 0.01.

CURRENT BIBLIOGRAPHY *

Compiled by

EVA R. HAWKINS

The National Health Library

Abel, Theodora M. Free designs of limited scope as a personality index; a comparison of schizophrenics with normal, subnormal, and primitve culture groups. Character and personality, 7:50–62, September 1938.

Ackerman, Nathan W., M.D. Paranoid state with delusions of injury by "Black Magic." Bulletin of the Menninger clinic, 2:118–26, July 1938.

Albright, Sue and Gambrell, Helen. Personality traits as criteria for the psychiatric treatment of adolescents. Smith college studies in social work, 9:1–26, September 1938.

Alexander, Franz, M.D. Psychoanalysis comes of age. Psychoanalytic quarterly, 7:299–306, July 1938.

Alschuler, Rose H. Guidance needed. Progressive education, 15:459–67, October 1938.

Alvarez, Walter C., M.D. Nerves and indigestion. Hygeia, 16:776–78, September 1938.

American eugenics society. Practical eugenics; aims and methods of the American eugenics society. Eugenics review (London), 30:187–97, October 1938.

American orthopsychiatric association. Section meeting on culture and personality (1938); Chairman: Franz Alexander, M.D. American journal of orthopsychiatry, 8:587–626, October 1938.

Contents: A tentative analysis of the variables in personality development, by Franz Alexander, M.D. Personality formation in a social context, by W. L. Warner. Critique, by Gregory Zilboorg, M.D. Conflicts in immigrants, by William French, M.D. Attitudes toward psychotics, by H. L. Witmer. Language factors, by H. S. Sullivan, M.D. A Chinese man, by Dr. Saul. Historical aspects, by Prof. Borgese. Interactions, by E. W. Burgess. Family attitudes, by William Healy, M.D. Health habits, by D. E. Hall. Cultural control and physiological autonomy, by L. K. Frank.

Anderson, Victor V., M.D. The integration of psychiatry with education. Journal of nervous and mental disease, 88:337–55, September 1938.

Angyal, Andras, M.D. The concept of bionegativity. Psychiatry, 1: 303–7, August 1938.

Anonymous. They said I was mad. Forum, 100:231–37, November 1938.

Arbuthnot, May Hill. Transitions in discipline. Childhood education, 15: 101–7, November 1938.

Arlitt, Ada H. The citizen in the nursery. National parent-teacher, 33:8–9, November 1938.

Arnold, Nita M., M.D. Coöperation, the secret of happy usefulness. International journal of religious education, 15:12–13, December 1938.

Baker, G. Derwood. Years of transition—pre-adolescent and early adolescent development. Progressive education, 15: 540–52, November 1938.

Barahal, Hyman S., M.D. Water intoxication in a mental case. Psychiatric quarterly, 12:767–71, October 1938.

Barnes, Margaret R. and Fetterman, J. L., M.D. Mentality of dispensary epileptic patients. Archives of neurology and psychiatry, 40:903–10, November 1938.

Bartlett, Harriett M. Social case work; the central function of a medical social service department. Family, 19:247–51, December 1938.

Bentley, Inez A., M.D. and Hirsdansky, Sara, M.D. Psychiatric approach to the problem of mental deficiency in school children. Medical woman's journal, 45:253–57, September 1938.

* This bibliography is uncritical and does not include articles of a technical or clinical nature.

Beres, David, M.D. and Schatia, Viva, M.D. Heredity in disease; a review of the recent literature. Journal of pediatrics, 13:555–81, October 1938.

Berliner, Bernhard, M.D. The psychogenesis of a fatal organic disease. Psychoanalytic quarterly, 7:368–79, July 1938.

Blackburn, J. M. Methods of estimating intelligence and personality and their applications. Journal of mental science (London), 84:1008–53, November 1938.

Blakeslee, Ruth O. Individualized service to families in the social security program. Family, 19:177–80, October 1938.

Bolles, M. Marjorie, Rosen, G. P. and Landis, Carney. Psychological performance tests as prognostic agents for the efficacy of insulin therapy in schizophrenia. Psychiatric quarterly, 12:733–37, October 1938.

Bollmeier, Ludolf N., M.D. A paranoid mechanism in male overt homosexuality. Psychoanalytic quarterly, 7: 357–67, July 1938.

Britt, Robert E., M.D. The neurotic factor in disease. Journal of the Missouri state medical association, 35:440–43, November 1938.

Brown, Warren T., M.D., Preu, P.W., M.D. and Sullivan, A. J., M.D. Ulcerative colitis and the personality. American journal of psychiatry, 95: 407–20, September 1938.

Brown, William. The psychological basis of ethics, with some observations on group morality. Character and personality, 7:1–13, September 1938.

Brüel, Oluf. A moving picture as a psychopathogenic factor: a paper on primary psychotraumatic neurosis. Character and personality, 7:68–76, September 1938.

Bryngelson, Bryng. "Unaccustomed as I am—." Hygeia, 16:968–70, November 1938.

Burbury, W. M., M.B. The selection of cases for psychiatric treatment in guidance clinics. Public health (London), 51:333–36, August 1938.

Burkhard, Russell. Parental pests. Hygeia, 16:794–95, September 1938.

Burlingham, Susan. Therapeutic effects of a play group for pre-school children. American journal of orthopsychiatry, 8:627–38, October 1938.

Caldwell, Morris G. The sociological tract: the spatial distribution of social data (a selected annotated bibliography). Psychiatry, 1:379–85, August 1938.

Cammarata, Joseph A., M.D. Psychology in medicine. Pennsylvania medical journal, 42:31–34, October 1938.

Carmichael, Francis A., M.D. Evaluation of the mental factor in treatment of physical disorders. Journal of the Missouri state medical association, 35:436–40, November 1938.

Carmichael, Hugh T., M.D. and Kenyon, A. T., M.D. Eunuchoidism; a psychiatric and endocrine study of six cases. Archives of neurology and psychiatry, 40:717–42, October 1938.

Casey, Robert P. The psychoanalytic study of religion. Journal of abnormal and social psychology, 33:437–52, October 1938.

Cassat, Rowena W. Emotional ties that hinder. National parent-teacher, 33:25–27, November 1938.

Challman, Robert C. Problems of pupil adjustment requiring counseling. Teachers college record, 40:34–39, October 1938.

Chassell, Joseph, M.D. Limitations of suggestive psychotherapy. Psychiatry, 1:309–16, August 1938.

Clothier, Florence, M.D. The social development of the young child. Child development, 9:285–91, September 1938.

Cohen, Louis H., M.D. The early effects of metrazol therapy in chronic psychotic over-activity. American journal of psychiatry, 95:327–33, September 1938.

Cook, L. C., M.B. The range of mental reaction states influenced by cardiazol convulsions. Journal of mental science (London), 84:664–67, September 1938.

Coriat, Isador H., M.D. Current trends in psychoanalysis. Psychoanalytic review, 25:445–52, October 1938.

Crampton, C. Ward and Partridge, E. D. Social adjustments associated with individual differences among adolescent boys. Journal of educational sociology, 12:66–72, October 1938.

Crowley, Ralph M., M.D. Use of insulin in certain psychiatric disorders. Virginia medical monthly, 65:678–82, November 1938.

Davis, D. Elizabeth. The operation of the social case work function within the function of a children's hospital. Family, 19:252–57, December 1938.

Davis, John E. To every child—a chance. Hygeia, 16:1117–19, December 1938.

Deutsch, Helene. Folie à deux. Psychoanalytic quarterly, 7:307–18, July 1938.

Doane, Joseph C., M.D. Signs of mental disorder. Modern hospital, 51: 59–60, October 1938.

Dollard, John. Hostility and fear in social life. Social forces, 17:15–29, October 1938.

Dorn, Harold F. The incidence and future expectancy of mental disease. Public health reports, U. S. Public health service, 53:1991–2004, November 11, 1938.

Dorsey, John M., M.D. Discovering reality. National parent-teacher, 33: 16–19, October 1938.

Dreyer, Philip V., M.D. The treatment of syphilitic psychoses with tryparsamide and therapeutic fever. Journal of the Missouri state medical association, 35:353–55, September 1938.

Driscoll, Gertrude P. Guidance at the elementary level. Teachers college record, 40:25–33, October 1938.

East, E. M. Insanity and genius. Journal of heredity, 29:275–79, August 1938.

East, W. Norwood, M.D. Observations on narcotic drug addiction. Mental hygiene (London), 4:115–27, October 1938.

Eidelberg, Ludwig. Pseudo-identification. International journal of psychoanalysis (London), 19:321–30, July 1938.

Ellenwood, James L. Are you a dictator? Parents' magazine, 13: 16–17, 48–51, November 1938.

Erickson, Isabel. The nursing care of chronic alcohol addiction. Bulletin of the Menninger clinic, 2:113–17, July 1938.

Erickson, Isabel and Ramsey, Mary. Nursing care in shock therapy. Bulletin of the Menninger clinic, 2:155–60, September 1938.

Faber, Marion. A survey of the status of mental nursing today. Hospital management, 46:25–29, August 1938.

Fabing, Howard D., M.D. A neurologic note on traffic lights. Journal of the American medical association, 111: 1166–68, September 24, 1938.

Faver, Harry E., M.D. Convulsions in schizophrenia. Psychiatric quarterly, 12:725–32, October 1938.

Fechheimer, Richard. Education isn't "patent medicine." Hygeia, 16:779–81, September 1938.

Feldman, Edith. Why children discontinue child guidance treatment. Smith college studies in social work, 9:27–98, September 1938.

Feldman, Harold, M.D., Fiero, R. P., M.D. and Hunt, R. C., M.D. Influence of insulin treatment upon schizoid personality traits. Psychiatric quarterly, 12:710–15, October 1938.

Fisher, Mary S. Health management in the home. Child study, 16:3–4, 30, October 1938.

Foster, Helen L. Case work in correspondence. Family, 19:260–65, December 1938.

Foster, Robert G. Preparing our children for marriage. National parent-teacher, 33:21–23, December 1938.

Fox, Evelyn. Modern developments in mental welfare work. Eugenics review (London), 30:165–73, October 1938.

Foxe, Arthur N., M.D. Omnipotence as a defense. Psychoanalytic review, 25:505–8, October 1938.

Foxe, Arthur N., M.D. Psychiatric classification in a prison. Psychiatric quarterly, 12:617–28, October 1938.

Frank, Lawrence K. The child's outlook on the world. Progressive education, 15:453–58, October 1938.

Frank, Lawrence K. The needs of the child. National parent-teacher, 33: 5–7, December 1938.

Freedman, Harry L., M.D. The rôle of psychiatry in prisons. Journal of criminal law and criminology, 29: 353–61, September–October 1938.

Freud, Sigmund. Moses an Egyptian. International journal of psychoanalysis (London), 19:291–98, July 1938.

Fries, Margaret E., M.D. Some psychological factors in the physical health of children. Child study, 16: 5–6, 30–31, October 1938.

Fries, Margaret E., M.D. and Lewi, Beatrice. Interrelated factors in development; a study of pregnancy, labor, delivery, lying-in period and childhood. American journal of orthopsychiatry, 8:726–52, October 1938.

Frost, Isaac, M.B. Home-sickness and immigrant psychoses; Austrian and German domestic servants the basis of study. Journal of mental science (London), 84:801–47, September 1938.

Gardner, William E., M.D. Mental hygiene as related to the psychoneuroses. Journal of the American medical association, 111:1094–98, September 17, 1938.

Gesell, Arnold, M.D. The fears of children. Public health nursing, 30: 586–89, October 1938.

Gesell, Arnold, M.D. A half century of science and the American child.

Child study, 16:35–37, 78–79, November 1938.

Gesell, Arnold, M.D. Scientific approaches to the study of the human mind. Science, 88:225–30, September 9, 1938.

Gillean, Susan. The responsibility of private child welfare agencies for adoptions. Child welfare league of America, Bulletin, 17: 1–2, 4–5, June 1938.

Gilmour, John R., M.B. The low-rate private patient and some changes. Journal of mental science (London), 84:596–607, September 1938.

Glueck, Bernard, M.D. Psychoanalytic psychiatry and child study. Child study, 16:40–42, November 1938.

Goldstein, Hyman. Leader or follower —which will your child be? Hygeia, 16:878–80, October 1938.

Goldstein, Hyman H., M.D., Dombrowski, E. F., M.D. and Edlin, J. V., M.D. Multiple therapy in the psychoses. American journal of psychiatry, 95: 321–25, September 1938.

Griffin, John D. M., M.D. The contribution of child psychiatry to mental hygiene. Canadian public health journal, 29:550–53, November 1938.

Griffiths, Gwenvron M., M.D. and Fox, J. T., M.D. Rhythm in epilepsy. Lancet (London), 235:409–16, August 20, 1938.

Grossman, Jean S. Family fireworks. Parents' magazine, 13:18–19, 56–60, November 1938.

Grossman, Jean S. The road back. Child study, 16:7–9, 22, October 1938.

Grotjahn, Martin, M.D. Psychiatric observations of schizophrenic patients during metrazol treatment. Bulletin of the Menninger clinic, 2: 142–50, September 1938.

Grotjahn, Martin, M.D. Some features common to psychotherapy of psychotic patients and children. Psychiatry, 1:317–22, August 1938.

Gruenberg, Sidonie M. Family life—then and now. Child study, 16:44–46, 74, November 1938.

Guthrie, Riley H., M.D. A review of three hundred general-hospital patients admitted to the Boston psychopathic hospital during 1937. New England journal of medicine, 219: 217–22, August 18, 1938.

Habbe, Stephen. Normal abnormalities. Hygeia, 16:782–86, 837, 852, September 1938.

Hackbusch, Florentine. The need of psychological examinations in the determination of mental deficiency. Mental health bulletin, Department of welfare, Pennsylvania, 16:5–11, October 15, 1938.

Hamlin, Percy G., M.D. Psychological conditioning. Virginia medical monthly, 65:605–9, October 1938.

Harding, George T., M.D. Mental and emotional instability; a problem of late midlife. Industrial medicine, 7:632–35, October 1938.

Harmon, Darell B. The teacher and delinquency, from the mental-hygiene point of view. Journal of educational sociology, 12:78–86, October 1938.

Harris, Arthur, M.D. Cardiazol treatment of schizophrenia. Journal of mental science (London), 84:735–75, September 1938.

Harris, Arthur, M.D. The prognosis of anxiety states. British medical journal (London), p. 649–54, September 24, 1938.

Henderson, Bernice M. Parental attitudes toward first-grade achievement. Understanding the child, 7: 21–25, October 1938.

Hendrick, Ives, M.D. "The ego and the defense mechanisms": a review and discussion. Psychoanalytic review, 25:476–97, October 1938.

Henry, Hugh C., M.D. Current methods of treating mental cases in Virginia. Virginia medical monthly, 65:664–67, November 1938.

Hinsie, Leland E., M.D. Neurosyphilis in children. Archives of pediatrics, 55:627–31, October 1938.

Hoffmann, Martin H., M.D. The expert witness and the insanity defense plea. American journal of medical jurisprudence, 1:12–18, September 1938.

Hohman, Leslie B., M.D. The abortion of recurrent depressive psychoses. Journal of nervous and mental disease, 88:273–80, September 1938.

Hollis, Florence. Individualized service to families in the private agency. Family, 19:181–87, October 1938.

Horwitz, William A., M.D., Blalock, J. R., M.D. and Harris, M. M., M.D. Occurrence of relapses in patients treated with insulin hypoglycemic shock. Psychiatric quarterly, 12: 716–21, October 1938.

Houston, William R., M.D. The doctor himself as a therapeutic agent. Diplomate, 10:199–206, October 1938.

Hubert, W. H. deB. The psychological approach to childhood. Mother and child (London), 9:210–13, September 1938.

Hughes, Charlotte. If your child is exceptional. Parents' magazine, 13: 26–28, 97, December 1938.

Humphreys, Edward J., M.D. Present day research trends in the field of human deficiency. Journal of nervous and mental disease, 88:474–90, October 1938.

Hunt, Mary de Vere. Report on the Fifth European mental hygiene reunion. Mental hygiene (London), 4: 108–14, October 1938.

Huschka, Mabel, M.D. The incidence and character of masturbation threats in a group of problem children. Psychoanalytic quarterly, 7: 338–56, July 1938.

Imus, Henry A. Visual factors in reading. Understanding the child, 7:8–10, 15, October 1938.

Ingham, Samuel D., M.D. Some neurologic aspects of psychiatry. Journal of the American medical association, 111:665–68, August 20, 1938.

International medical congress for psychotherapy, 10th, Oxford, July 29 to August 2, 1938. Summaries of various papers. Journal of mental science (London), 84:1054–92, November 1938.

Isakower, Otto. A contribution to the patho-psychology of phenomena associated with falling asleep. International journal of psychoanalysis (London), 19:331–45, July 1938.

Jensen, Howard E. Mental hygiene and family counseling. Social forces, 17:90–98, October 1938.

Jersild, Catherine L. Overcoming fear. Parents' magazine, 13:22, 55–57, December 1938.

Kallman, Franz J., M.D. Eugenic birth control in schizophrenic families. Journal of contraception, 3:195–99, November 1938.

Kanner, Leo, M.D. Some pediatric problems of behavior in infancy and early childhood. Journal of pediatrics, 13:417–33, September 1938.

Katz, Hedi. Creative music in the progressive education programme for the exceptional child. Mental welfare (London), 19:105–11, October 1938.

Kauffman, Margaret. Supervision of case work staffs. Family, 19:196–202, October 1938.

Kawin, Ethel. Implications of individual differences at the first grade level. American journal of orthopsychiatry, 8:654–72, October 1938.

Kelman, Harold, M.D. and Field, Hans, M.D. Psychosomatic relationships in pruriginous lesions. Journal of nervous and mental disease, 88:627–43, November 1938.

Kephart, Newell C. A method of heightening social adjustment in an institutional group. American journal of orthopsychiatry, 8:710–18, October 1938.

Kirchheimer, Otto. Recent trends in German treatment of juvenile delinquency. Journal of criminal law and criminology, 29:362–70, September–October 1938.

Klein, Rema G. Specialized instruction in a study home for children. Child welfare league of America bulletin, 17:3, 4–6, October 1938.

Knight, Robert P., M.D. The psychoanalytic treatment in a sanatorium of chronic addiction to alcohol. Journal of the American medical association, 111:1443–48, October 15, 1938.

Kraines, S. H., M.D. Indices of body build, their relation to personality. Journal of nervous and mental disease, 88:309–15, September 1938.

Krueger, E. T. Some methodological problems of social psychology and social psychiatry. Social forces, 17: 41–47, October 1938.

Ladell, R. Macdonald, M.B. Medico-psychological practice. Lancet (London), 235:1209–10, November 19, 1938.

Lander, Joseph, M.D. Epilepsy. Family, 19:257–59, December 1938.

Landers, John J., M.B. Observations on two hundred Dartmoor convicts. Journal of mental science (London), 84:960–79, November 1938.

Langer, Marion F. A foster home agency experiments with a nursery school. Family, 19: 228–33, November 1938.

Larkin, E., M.B. Psychological aspects of insulin shock therapy; a psychosomatic study. Journal of mental science (London), 84:668–71, September 1938.

Lawton, George. Mental hygiene and scholarship. School and society, 48:304–6, September 3, 1938.

Lawton, George. What is a well-adjusted person? Journal of adult education, 10:395–96, October 1938.

Leonidoff, Aleksel A., M.D. Control of tuberculosis in the Hudson River state hospital. Psychiatric quarterly, 12:754–66, October 1938.

Levin, Max, M.D. Morbid hunger in relation to narcolepsy and epilepsy. Journal of nervous and mental disease, 88:414–16, October 1938.

Levy, David M., M.D. "Release therapy" in young children. Psychiatry, 1:387–90, August 1938.

Levy, John, M. A., M.D. (Obituary by S. H. Tulchin.) American journal of orthopsychiatry, 8:762–63, October 1938.

Lewis, Aubrey, M.D. States of depression; their clinical and ætiological differentiation. British medical journal (London), p. 875–78, October 29, 1938.

Lin, Mousheng Hsitien. Antistatism; essay in its psychiatric and cultural analysis. Psychiatry, 1:391–417, August 1938. (To be continued.)

Linton, Ralph. Culture, society and the individual. Journal of abnormal and social psychology, 33:425–36, October 1938.

Lloyd, Wilma. How can we understand our children? Childhood education, 15:53–55, October 1938.

Lloyd-Jones, Esther. Preparation for psychological counseling. Teachers college record, 40:71–79, October 1938.

Loehrig, Catherine H. The work of the school psychologist. Mental health bulletin, Department of welfare, Pennsylvania, 16:15–18, October 15, 1938.

Lowenfeld, Margaret. The whole child. Mother and child (London), 9:247–51, October 1938.

Lowenstein, Pearl and Svendsen, Margaret. Experimental modification of the behavior of a selected group of shy and withdrawn children. American journal of orthopsychiatry, 8:639–53, October 1938.

Lunt, Lawrence K., M.D. Attitudes in relation to illness. New England journal of medicine, 219:557–61, October 13, 1938.

Lynch, Lincoln D. What a superintendent expects from mental hygiene. Understanding the child, 7:6–7, October 1938.

McCarthy, Dorothea. Guiding children's social development. Childhood education, 15:113–17, November 1938.

McDaniel, Frederick L., M.D. Mental diseases in the United States navy. United States naval medical bulletin, 36:536–42, October 1938.

Macfarlane, Jean W. Family influences on children's personality development. Childhood education, 15:55–59, October 1938.

Macfarlane, Jean W. Some findings from a ten-year guidance research program. Progressive education, 15:529–35, November 1938.

Maclay, W. S., M.D., Guttmann, E., M.D. and Mayer-Gross, W., M.D. Spontaneous drawings as an approach to some problems of psychopathology. Proceedings of the Royal society of medicine (London), 31:1337–50, September 1938.

MacLeod, W. Malcolm. General hospital care for nervous patients. Modern hospital, 51:66–67, November 1938.

Malzberg, Benjamin. Is birth order related to the incidence of mental disease? American journal of physical anthropology, 24:91–104, July–September 1938.

Marker, John I., M.D. Depressive states in general practice. Journal of the Iowa state medical society, 28:443–47, September 1938.

Masserman, Jules H., M.D. and Carmichael, H. T., M.D. Diagnosis and prognosis in psychiatry; with a follow-up study of the results of short-term general hospital therapy of psychiatric cases. Journal of mental science (London), 84:893–946, November 1938.

Mayer-Gross, W., M.D. The early diagnosis of schizophrenia. British medical journal (London), p. 936–39, November 5, 1938.

Menninger, William C., M.D. The results with metrazol as an adjunct therapy in schizophrenia and depressions. Bulletin of the Menninger clinic, 2:129–41, September 1938.

Menninger, William C., M.D. The treatment of chronic alcohol addiction. Bulletin of the Menninger clinic, 2:101–12, July 1938.

Meyer, Adolf, M.D. The bridge between parent and scientist. Child study, 16:38–39, 80, November 1938.

Meyer, Adolf, M.D. Dealing with mental diseases. Modern hospital, 51:87–89, September 1938.

Michaels, Joseph J., M.D. and Goodman, S. E. Enuresis and other factors in normal and in psychotic persons. Archives of neurology and psychiatry, 40:699–706, October 1938.

Middleton, Herbert R. First-grade reading: an appraisal. Understanding the child, 7:11–15, October 1938.

Mikkelsen, Harold W., M.D. What to do for the blues. Life and health, 53:4–5, 18, November 1938.

Milici, Pompeo, M.D. and Von Salzen, C. F., M.D. Situational schizophrenia. Psychiatric quarterly, 12:650–68, October 1938.

Minski, Louis, M.D. Psychopathy and psychoses associated with alcohol. Journal of mental science (London), 84:985–90, November 1938.

Moore, Madeline U. Psychiatric services in case work agencies. Family, 19:216–23, November 1938.

Moore, Thomas V. The psychotic and prepsychotic character. Character and personality, 7:14–18, September 1938.

Morphy, Arthur G., M.D. A review of recent literature on neuroses and psychoneuroses. Canadian medical association journal (Montreal), 39: 282–86, September 1938.

Munro, T. A., M.B. Consanguinity and mental disorder. Journal of mental science (London), 84:708–14, September 1938.

Murphy, Katherine M. Psychology in tuberculosis. Trained nurse and hospital review, 101:227–30, September 1938.

Nation, Paris M., M.D. Some general aspects of modern therapy in mental disorders. Illinois medical journal, 74:276–78, September 1938.

Novick, Rudolph G., M.D. Study of the treatment of epilepsy. Illinois medical journal, 74:366–69, October 1938.

Oberndorf, Clarence P., M.D. Psychoanalysis of married couples. Psychoanalytic review, 25:453–75, October 1938.

O'Brien, Frank J., M.D. Case studies: Gerald, a boy who could not read. Understanding the child, 7:26–29, October 1938.

Oettinger, Katherine B. Adults in the making. Public health nursing, 30: 518–24, September 1938.

Oltman, Jane E., M.D. and Freidman, Samuel, M.D. Acute heterosexual inadequacy. Psychiatric quarterly, 12:669–78, October 1938.

Orenstein, Leo L., M.D. and Schilder, Paul, M.D. Psychological considerations of the insulin treatment in schizophrenia. Journal of nervous and mental disease, 88:397–413, October 1938; 644–60, November 1938.

O'Shea, Harriet E. A mental hygienist looks at physical education. National parent-teacher, 33:19–21, August–September 1938.

Owensby, Newdigate M., M.D. Convulsive therapy in mental disorders. Southern medical journal, 31:1164–66, November 1938.

Page, James and Warkentin, John. Masculinity and paranoia. Journal of abnormal and social psychology, 33:527–31, October 1938.

Palmer, Harold D., M.D. and Sherman, S. H., M.D. The involutional melancholia process. Archives of neurology and psychiatry, 40:762–88, October 1938.

Parker, Z. Rita, M.D. Psychological symptoms in adolescence. Preventive medicine, 8:126–32, 142, September 1938.

Parsons, E. H. and Overholser, Winfred, M.D. Saint Elizabeths hospital. Military surgeon, 83:227–34, September 1938.

Patry, Frederick, L., M.D. How shall we live with our fellow men? Journal of school health, 8:223–25, October 1938.

Penrose, L. S., M.D. Some genetical problems in mental deficiency. Journal of mental science (London), 84: 693–707, September 1938.

Peterson, Frederick, M.D. (Obituary.) Journal of nervous and mental disease, 88:558–61, October 1938.

Pierce, Marion. Growing pains. Childhood education, 15:118–21, November 1938.

Pilpel, Cecile. Study groups, 1888–1938. Child study, 16:47–48, November 1938.

Piotrowski, Zygmunt. The prognostic possibilities of the Rorschach method in insulin treatment. Psychiatric quarterly, 12:679–89, October 1938.

The placing of children in families. Canadian welfare summary (Ottawa), 14:44–54, July 1938; 14–34, September 1938. (Concluded from May 1938 issue.)

II. Principles underlying the placing of children in care outside their own homes.

III. Considerations in the organization of child placing measures.

Plant, James S., M.D. New Jersey looks at its young delinquents. Survey midmonthly, 74:277–79, September 1938.

Pollack, Benjamin, M.D. Etiological factors in suicide. Medical times, 66:421–25, 457, September 1938.

Popenoe, Paul. Extravert or introvert? Hygeia, 16:971–73, 1037, 1048, November 1938.

Popenoe, Paul. Left-handedness. Hygeia, 16:893–95, 952–54, October 1938.

Prevention of mental disease; discussion by Glenn Myers, M.D., J. M. Neilsen, M.D. and M. H. Hirschfeld, M.D. California and western medicine, 49:215–20, September 1938.

Pym, Thomas W. Psychology and sense of sin. Mental hygiene (London), 4:132–35, October 1938.

Rees, John R., M.D. The magistrate and delinquency. Mental hygiene (London), 4:127–32, October 1938.

Render, Helena W. Successful psychiatric nursing. Modern hospital, 51: 61, October 1938.

Reynolds, Rosemary. Do we still believe case work is needed in a public relief agency? Family, 19:171–77, October 1938.

Robertson, Wanda. Knowing children at school. Childhood education, 15: 64–68, October 1938.

Robinson, Bruce. Temper tantrums. Journal of adult education, 10:390–94, October 1938.

Rogers, Gladys G. and Thomas, L. C. Emotional adjustment of the spastic child. Part 2. Crippled child, 16: 91–93, October 1938. (Concluded from August issue.)

Rosanoff, Aaron J., M.D. The present status of fever therapy in the prevention and treatment of neurosyphilis. American journal of psychiatry, 95:347–51, September 1938.

Rosenberg, Ella M. and Shapiro, M. S. The significance of the application interview. Family, 19:265–71, December 1938.

Ross, Elizabeth H. Dependence and independence. Child study, 16:10–12, October 1938.

Rowland, Howard. Interaction processes in the state mental hospital. Psychiatry, 1:323–37, August 1938.

Ryan, W. Carson, Jr. The educational significance of the Norwood school project. Understanding the child, 7: 3–5, October 1938.

Sakel, Manfred, M.D. The influence of pharmacological shocks on the psychoses. Journal of mental science (London), 84:626–36, September 1938.

Saul, Leon J., M.D. Telepathic sensitiveness as a neurotic symptom. Psychoanalytic quarterly, 7:329–35, July 1938.

Schipper, Irving S., M.D. The use of rabies vaccine in the treatment of epilepsy. Illinois medical journal, 74:174–75, August 1938.

Schmideberg, Melitta. The mode of operation of psychoanalytic therapy. International journal of psychoanalysis (London), 19:310–20, July 1938.

Schumacher, Henry C., M.D. Mental hygiene and the pastoral ministry. Catholic charities review, 22: 274–76, November 1938.

Seabury, David. Are there any bad children? International journal of religious education, 15:7, 34, October 1938.

Sheldon, Charles P., M.D. and Ziegler, L. H., M.D. Marriage among mental defectives. Journal of the American medical association, 111:1982–86, November 26, 1938.

Sherwin, May R. Knowing children through personality studies. Childhood education, 15:76–78, October 1938.

Skodak, Marie. The mental development of adopted children whose true mothers are feebleminded. Child development, 9:303–8, September 1938.

Slawson, John. The use of the authoritative approach in social case work in the field of delinquency. American journal of orthopsychiatry, 8:673–78, October 1938.

Snyder. Laurence H. Present trends in the study of human inheritance. Eugenical news, 23:61–66, July–August 1938.

Sommer, Conrad S., M.D. The treatment of mental diseases. Mental health bulletin, Illinois society for mental hygiene, 17:1–4, September–October 1938.

Southwick, Walter E. The kindred file; its value for genetical studies of defective individuals. Journal of heredity, 29:398–400, October 1938.

Spencer, Douglas. Mental hygiene for teachers. Teachers college record, 40:40–50, October 1938.

Spies, Tom D., M.D. and others. The mental symptoms of pellagra; their relief with nicotinic acid. American journal of the medical sciences, 196:461–75, October 1938.

Spitz, Gertrude T. Nutrition of first-grade children. Understanding the child, 7:16–20, 25, October 1938.

Starks, Hamlin A., M.D. Subjective experiences in patients incident to insulin and metrazol therapy. Psychiatric quarterly, 12:699–709, October 1938.

Stein, Calvert, M.D. Practical aspects of child guidance; a critical analysis of 500 cases. New England journal of medicine, 219:844–47, November 24, 1938.

Steiner, Lee R. Case work as a private venture. Family, 19:188–96, October 1938.

Stolz, Herbert R. Understanding the child's needs. Journal of the National education association, 27:194, October 1938.

Stone, Esther H., M.D. Psychosis with toxic goiter. Medical woman's journal, 45:294–95, 299, October 1938.

Strang, Ruth. The teacher's contribution to the guidance of children. Teachers college record, 40:16–24, October 1938.

Strauss, Alfred, M.D. and Werner, Heinz. Deficiency in the finger schema in relation to arithmetic disability (finger agnosia and acalculia). American journal of orthopsychiatry, 8:719–25, October 1938.

Swanson, Lydia V. Troubles and teamwork. National parent-teacher, 33:18–20, December 1938.

Symonds, Percival M. A study of parental acceptance and rejection. American journal of orthopsychiatry, 8:679–88, October 1938.

Symposium on the psychopathic personality. Archives of neurology and psychiatry, 40:845–53, October 1938.

Thompson, Clara. Development of awareness of transference in a markedly detached personality. International journal of psycho-analysis (London), 19:299–309, July 1938.

Tiebout, Harry M., M.D. Mental hygiene problems of the college student. Preventive medicine, 8:188–97, November 1938.

Tietz, Esther B., M.D. Birth control and mental hygiene. Birth control review, 23:115–16, October 1938.

Tilney, Frederick, M.D. (Obituary by Louis Casamajor, M.D.) Journal of nervous and mental disease, 88:561–65, October 1938.

Turner, Clair E. How shall we rear our children? Some thoughts on the importance of consistency. Journal of school health, 8:218–20, October 1938.

Van der Veer, Adrian H., M.D. and Reese, Hans H., M.D. Treatment of schizophrenia with insulin shock; personal experiences and general review. American journal of psychiatry, 95:271–90, September 1938.

Van de Water, Marjorie. Suicide is a disease. Science news letter, 34:10–12, July 2, 1938.

Washburne, Carleton. Education or the three R's. National parent-teacher, 33:5–9, August–September 1938.

Weigert-Vowinkel, Edith, M.D. The cult and mythology of the magna mater from the standpoint of psychoanalysis. Psychiatry, 1:347–78, August 1938.

Welfare, Marjorie U. Holiday homes for mental patients. Mental welfare (London), 19:113–16, October 1938.

Wellman, Beth L. Guiding mental development. Childhood education, 15:108–12, November 1938.

Wile, Ira S., M.D. Mental disorders as a factor in divorce. Eugenical news, 23:81–92, September–October 1938.

Wile, Ira S., M.D. and Davis, R. M. A study of the behavior of 250 children with mental age ten years. American journal of orthopsychiatry, 8:689–709, October 1938.

Williams, James N., M.D. Present preventive programs for feeble-minded and mentally ill people in Virginia. Virginia medical monthly, 65:609–11, October 1938.

Winkelman, Nathaniel W., M.D. Metrazol treatment in schizophrenia; a study of thirty-five cases in private practice, complications and their prevention. American journal of psychiatry, 95:303–16, September 1938.

Woodard, James W. The relation of personality structure to the structure of culture. American sociological review, 3:637–51, October 1938.

Woods, Andrew H., M.D. Conditions for testing therapeutic methods in schizophrenia. Journal of the Iowa state medical society, 28:462–63, September 1938.

Woolley, Lawrence F., M.D. Studies in obsessive ruminative tension states. VI. Treatment. Psychiatric quarterly, 12:772–92, October 1938.

Zachry, Caroline B. Later childhood—some questions for research. Progressive education, 15:522–28, November 1938.

Zahorsky, John, M.D. Psychiatry and pediatrics. Archives of pediatrics, 55:717–21, November 1938.

Zilboorg, Gregory, M.D. "What man has made of man." Psychoanalytic quarterly, 7:380–98, July 1938.

Zubin, Joseph. A technique for measuring like-mindedness. Journal of abnormal and social psychology, 33:508–16, October 1938.